Division	of Health Service Regu	ulation			FORM APPROVED
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPLETED
		MHL0601258	B. WING		01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
			ARON ROAD W		
STRATEG	GIC BEHAVIORAL CENTE	R-CHARLOTTE	OTTE, NC 2821		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	(X5) BE COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	
V 000	INITIAL COMMENTS		V 000	Please know that SBC, Charlotte is	
	MATTIAL COMMENT	•		profoundly humbled by this occurre	ence
	A complaint investiga	ation was conducted January		and takes these findings seriously. I	t has,
	8, 2018 through Janu	ary 12, 2018 and January		subsequently implemented a	
		17, 2018 to determine the		comprehensive corrective action plant	an to
		with the state rules for		address. The corrective actions are	
	_ •	Residential Treatment ne investigation resulted in		delineated in the following pattern:	•
	the identification of a	9			
		ed by a systemic failure to		The root cause (contributing factors	ds of
		of care to adolescent		the deficiencies in systems identified	
	behavioral health pat			for each:	2 4714
	Facility staff needents	ed to communicate resident's		a)The procedure for implementing t	the .
	, ,	tory to include but not limited		acceptable plan of correction for the	e
		al, suicidal, elopement,		specific deficiency identified;	
		ay, physically assaultive,		b)The date by which all corrective a	ctions
		nd property damage to care		will be completed and the monitori	
	staff thereby creating	an unsafe environment that		system will be in place.	79
		s for residents to destroy		c) The title of the person responsible	e for
		reate weapons used to		implementing the acceptable plan of	
	threaten staff.			correction	y
	Facility staff neolecte	ed to implement policies,		d)The monitoring procedure to ensu	ire that
4	procedures, elopeme	• •		the plan of correction is effective an	
		with a known history of			
	-	away. Ten residents eloped		the specific deficiency cited remains	
		anuary 1, 2018, which		corrected and/or in compliance with	n tne
		vention. Subsequently, on		regulatory requirements.	
		ice protection (eleven police			
	, .	d to secure the facility and			~
		nment which resulted in six being handcuffed and three			
		residents being arrested.			
	The facility's adminis	strative staff was notified on			
	•	1615 of the identification of			
	_	beginning on January 1,			
	2018.				

Based on the action plan submitted and the lack

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

ORDER

OF THE SERVICE REQUIATION

OF THE SERVICE REQUIATION

OF THE SERVICE REQUIATION

TITLE

OF THE SERVICE REQUIATION

OF THE SERVICE REQUIATION

OF THE SERVICE REQUIATION

TITLE

STATE FORM

OF THE SERVICE REQUIATION

OF

(X6) DATE

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 000 V 000 Continued From page 1 of time for monitoring systems and actions, the imminent threat (immediate jeopardy) was determined to be on-going. Therefore, based on in-office review, it is the finding of this agency that the facility has neglected to provide the services to assure the health, safety and welfare of the child and adolescents in a therapeutic and safe environment. As a result of the survey findings, the Section substantiated Rule violations that include: 10A NCAC 27D .0304 Clients Rights, Protecton from Harm, Abuse, Neglect or Exploitation 10A NCAC 27G .0201 Governing Body 10A NCAC 27G .0208 Client Services Findings reveal that, conditions at Strategic Behavioral Health- Charlotte present an imminent danger to the health, safety and welfare of the clients and that emergency action is required to protect the clients. V 105 GOVERNING BODY POLICIES Pursuant to North Carolina General Statutes Failure of the governing body to ensure a safe N.C.G.S. § 122C-23, the Division of Health environment for the delivery of care to Service Regulation (DHSR), North Carolina adolescent behavioral health residents #1, Department of Health and Human Services #2, #11, #7, #12, #9, #10, #8, #3, and #6 by not (DHHS), HEREBY SUSPENDS ADMISSIONS. communicating the resident's behavioral health history to include but not limited to violence, V 105 .0201 (A) (1-7) Governing Body Policies V 105 homicidal, suicidal, elopement, history of running away, physically assaultive, verbally 10A NCAC 27G .0201. GOVERNING BODY assaultive and property damage to care staff **POLICIES** thereby creating an unsafe environment (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

Division of Health Service Regulation

PRINTED: 02/07/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) The corrective action is written in the V 105 V 105 Continued From page 2 following format: operation of the facility and services; The root causes (contributing factors) of (2) criteria for admission; the deficiencies in systems identified, and (3) criteria for discharge; for each: (4) admission assessments, including: (A) who will perform the assessment; and a)The procedure for implementing the (B) time frames for completing assessment. acceptable plan of correction for the (5) client record management, including: specific deficiency cited; (A) persons authorized to document; b)The date by which all corrective action (B) transporting records; will be completed and the monitoring (C) safeguard of records against loss, tampering, system will be in place. defacement or use by unauthorized persons; (D) assurance of record accessibility to c) The title of the person responsible for authorized users at all times; and implementing the acceptable plan of (E) assurance of confidentiality of records. correction (6) screenings, which shall include: d)The monitoring procedure to ensure that (A) an assessment of the individual's presenting the plan of correction is effective and that problem or need: (B) an assessment of whether or not the facility specific deficiency cited remains corrected can provide services to address the individual's and/or in compliance with the regulatory requirements. (C) the disposition, including referrals and recommendations; Root cause (contributing factor): (7) quality assurance and quality improvement 1)Criteria for admission did not exclude 01/26/18 activities, including: patients with history of aggressive behavior, (A) composition and activities of a quality elopement, or pending legal charges assurance and quality improvement committee; (a) The criteria for admission to the PRTF for (B) written quality assurance and quality improvement plan; SBC Charlotte have been revised to now (C) methods for monitoring and evaluating the exclude patients with history of felonious quality and appropriateness of client care, behavior, history of elopement from a facility, including delineation of client outcomes and history of gang involvement, history of utilization of services: substance abuse disorder, and history of a (D) professional or clinical supervision, including conflict or affiliate relationship with a current

Division of Health Service Regulation

that area of service;

a requirement that staff who are not qualified

(E) strategies for improving client care;

(F) review of staff qualifications and a

professionals and provide direct client services

shall be supervised by a qualified professional in

resident of SBC Charlotte. Attachment "A"

within the acute care setting.

shows the revised criteria for SBC. Charlotte.

PRTF. SBC Charlotte is currently evaluating if

these same criteria will be applied to patients

FORM APPROVED Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 105 V 105 Continued From page 3 (b) Date of Completion: determination made to grant Approved by the Governing Board 01/26/2018 treatment/habilitation privileges: and now in place for PRTF units. (G) review of all fatalities of active clients who were being served in area-operated or contracted (c) Responsible Person: Chief Executive Officer residential programs at the time of death; (d) Monitoring Procedure to Ensure Correction: (H) adoption of standards that assure operational and programmatic performance meeting (a) (1) All admissions will be reviewed by the applicable standards of practice. For this Admissions Coordinator and the CEO for evidence of purpose, "applicable standards of practice" compliance with exclusionary criteria. means a level of competence established with (a) (2) On a weekly basis, SBC, Charlotte will conduct reference to the prevailing and accepted a PRTF Performance Improvement (PI)Committee methods, and the degree of knowledge, skill and meeting. A Governing Board Member will be a care exercised by other practitioners in the field; weekly participant to hear the results presented at this meeting. Attachment "B" delineates the standing agenda for this meeting. This Rule is not met as evidenced by: One of the indicators for review will be compliance Based on policy review, medical record review, with the exclusionary criteria for all prospective video review, police report review and staff admissions. The results, conclusions, and interview, the facility's governing body neglected recommendations will be forwarded by the Director to ensure a safe environment for the delivery of of Quality/Compliance/ Risk to the Hospital's care to adolescent behavioral health residents #1, monthly Quality/PI Council, Medical Executive #2, #11, #7, #12, #9, #10, #8, #3, and #6. Facility Committee and Governing Board at each of their staff neglected to communicate resident's respective meetings. This process will continue as behavioral health history to include but not limited presented on a go-forward basis and has no end to violence, homicidal, suicidal, elopement, history of running away, physically assaultive, verbally assaultive and property damage to care Root cause (contributing factor): 2/18/18 staff thereby creating an unsafe environment that 2)Patient details of prior history were not always allowed opportunities for residents to destroy present at the time of the initiation of the wood furniture and create weapons used to treatment plan and, thus, incorporated into same. threaten staff. (a)(1)) A hand-off form and formalized procedure

emergency) ...1. A group of RAs will be identified Division of Health Service Regulation

The findings included:

Review on 01/09/2018 of policy title "Code

the event of a Code Purple (psychiatric

Purple" last Reviewed/Revised 12/2016 revealed

"Policy: To correctly identify steps to be utilized in

V3NZ11

have been developed for implementation at SBC Charlotte, whereby, before a patient is received on a nursing unit from the intake admission area, the

Intake Assessor will verbally speak to the receiving

nurse to communicate an overview of the patient's

history, condition, and all precautions. These

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY
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		MU COACE	B. WING		04/47/0040
		MHL0601258			01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, S	TATE, ZIP CODE	
THE OT 1	TO TIDE! TO THE OWN TO				
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	IARON ROAD W		
		CHARL	OTTE, NC 2821	0	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	· · · · ·
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
TAG	REGULATORYOR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	IIAI E
V 105	Continued From page	e 4	V 105	precautions shall be written on the form e	
				"High Risk/High Alert Hand-off" and must	
		part of the Code Purple		to the receiving nurse for their acknowled	-
		taff member notes that a		and signature of same. Report on precauti	
	resident is exhibiting	signs of escalated behavior		be provided verbally (in person or per tele	•
	the Code Purple w	ill be announced over the		the receiving Unit nurse prior to the patie	_
	walkie-talkie with the	location attached to the		integrated into the nursing unit environment	
	code 7. Code Purp	ole team members will arrive		Unit nurse, in turn, will be responsible for	
	at the announced loo	ation and take direction and		implementing all orders and processes the	
	cues from the primar	y staff member on the scene		accompany the specific precautions. Attac	
	9. The primary sta	aff member on the team will		delineates the hand-off form and associat	
		with the RN to de-escalate		During daily Administrator on Call rounds,	
	•	sed on the level of danger to		will check the 15-minute check sheets for	
		ary staff and RN will cue the		of appropriate stickers signifying patient s	•
		embers into position if there		precautions that must correspond with th	
	•	I restrictive intervention"		precautions identified by the High Risk/Hi	_
	10 a 110 a 110 p 11, j 110 a		1	Hand-Off and, as ordered by the patient's	• •
	Review on 01/09/201	18 of policy title "Position		Deficiencies noted will be immediately co	
		ed Nurse" Date Approved:		Staff not meeting these requirements will	
	01/31/2015 revealed	• -		addressed on a progressive disciplinary ba	isis.
	NurseMay assume	= .			er vil
	•	assigned licensed nursing		All intake assessment staff and nursing sta	
		Li.e. assignments, monitoring		patient care responsibilities are being trai	
	•	_		through inservice activities on these requ	
		w-through and high acuity		In order to remain on the schedule, staff	
	•	respond and actively		attendance for the inservice are required	
	participate in a psycl			training on this requirement prior to any	scheduled
		utic Milieu 2. High visibility		work by the completion date.	
	•	uity and takes an active role		suff and the state of the state	5.1
	with indicated interven	entions"		Staff not meeting these requirements for	
				hand -off form and procedure will be add	ressed on a
		18 of the facility policy titled		progressive disciplinary basis.	
	•	ed/revised on 12/2016			
		ntain a safe and secure		(1) (1) 7 (7)	
	•	r all clients receiving inpatient		(b) (1) Date of Completion: 02/18/2018	
		e: 1. In the event of an		(a)(a) Responsible Responsible Responsible	designian a
		, 'CODE GREEN' and		(c)(1) Responsible Person: Director of Ac	imissions
		unced over the intercom. 2.		and Referral	
	Call (Name) police d	lepartment immediately. Give			
	names of the clients	. Have a description of the			
		ne, height, weight, sex, and			
		e arrive give a copy of the			
		t from the chart, 3. The RN			

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:	
		MIII 0004050	B. WING		04/47/2040
		MHL0601258			01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE	
		1715 SH	ARON ROAD WES	г	
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE CHARLO	OTTE, NC 28210		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIV	(X5) E COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	IAG	ACTION SHOULD BE	DATE
				CROSS-REFERENCED TO THE	
		_		(d). Monitoring procedure to ensure of	orrection
V 105	Continued From page	e 5	V 105	2)	
	will immediately notify	y the client's physician, the		(a)(1) During daily Administrator on Ca	ll rounds.
	•	Administrator on Call, and		the AOC will check the 15-minute chec	• .
		dian6. When the resident		for evidence of appropriate stickers sig	
		I notify the physician for a		patient safety precautions that must co	
	•	ther the resident is to be		with those precautions identified by th	· · · · · · · · · · · · · · · · · · ·
				Risk/High Alert Hand-Off and, as order	-
		ergency Department prior to		patient's physician. Deficiencies noted	•
	•	7. The client will immediately		immediately corrected.	
	•	ent precautions and the		100% of patient admissions will be rev	iewed at
		vill be consulted for any		the weekly SBC Charlotte PRTF PI Com	
	further orders."			meeting to review for compliance with	
	D 1 044401004	10 - 54 5 1116 11 1141 - d		"High Risk/High Alert Hand-Off form.	
		8 of the facility policy titled		Governing Board Member will be a we	eklγ
	•	ons" reviewed/revised		participant to hear the results presente	ed at this
		Residents who talk of		meeting.	
		pate with or know of a		The findings, conclusions, recommend	ations,
		actually run away will be		and actions will be forwarded by the D	irector of
		precautionsProcedure		Quality/Compliance/Risk to the Hospit	al's
	2. The adolescent			monthly Quality/PI Council, Medical Ex	kecutive
	elopement must write			Committee and Governing Board at ea	ch of their
	•	s prior to the run, the run		respective meetings. This process will	continue
	•	pired while the resident was		as presented on a go-forward basis an	d has no
		must complete prior to the		e <b>nd date</b> .	
	client being removed				em has 2/18/18
		rative should include an		(a)(2) A patient safety notification syst	
		alternative manner of coping,		been developed whereby all patients of	
	_	way. 3. Adolescents on		PRTF are having identification stickers	
	-	ns will have a bedtime of		color- coded with level of precautions	•
		4. Adolescents will be		their 15-minute round sheets. Accord	•
		ers to use as footwear. No		system, based on their identified safet	•
		ed. 5. Residents will not be		patients will have a red, yellow, or gre	
,		unit. 6. The individual's		precaution assigned. For example, pare elopement precautions will be identifi	
		e modified to reflect the		15-minute check sheet as such and sta	
		sary to maintain safety, i.e.		ensure that they adhere to all provision	
	•	mited phone calls. 7. A		Elopement policy including restriction	
		I be required to remove the		outdoor activities, as ordered by the p	
	-	nent precautions. 8. Criteria		physician. Attachment "D" delineates	
		m elopement precautions		process for patient safety notification.	
	•	us behavior to self or others,		During daily Administrator on Call rou	
		ious behavior, compliance		AOC will check the 15-minute check si	-
	with rules/medication	ns, the willingness to talk with		Will Greek die 15 milite Gleek si	

Division of	Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
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NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST					
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		CHARLO	TTE, NC 2821					
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	,			
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR				
ino				DEFICIENCY)				
V 40E	0	- 6	V 105	Evidence of appropriate stickers signifying	patient			
V 105	Continued From page	9 0	V 105	safety precautions that must correspond v	vith those			
	staff regularly about of	concerns/feelings."		precautions identified by the High Risk/High	sh Alert			
		•		Hand-Off and, as ordered by the patient's	physician.			
	Review on 01/11/201	8 of the facility policy titled		Deficiencies noted will be immediately cor	rected.			
	"Admission Procedur	• • •		Staff not meeting these requirements will	be			
	12/2016 revealed "	.B. Belongings are to be		addressed on a progressive disciplinary ba	sis.			
		nging list when brought to the		All nursing staff with patient care responsi				
	unitC. Patient may	keep at bedside a		being trained through inservice activities of				
	reasonable amount of	of clothing after a thorough		requirements. In order to remain on the s				
	contraband and safe	ty search. Clothing with		staff not in attendance for the inservice ar	•			
	drawstrings and othe	r potentially hazardous items		to receive training on this requirement pri	or to any			
	will not be allowed			scheduled work by the completion date.	use of the			
		•		Staff not meeting these requirements for				
	Review on 01/12/201	18 of the facility policy titled		hand -off form and procedure will be addr progressive disciplinary basis.	esseu on a			
		cks / Intervention Log"		progressive discipilitary basis.				
	reviewed/revised 12/	2016 revealed "PolicyThe		(b)(2) Date of Completion: 02/18/2018				
	client is observed at	minimum, every fifteen		(2)(-)				
		ated staff member to monitor		(c) (2) Responsible Person: Director of Nu	ırsing			
	• •	I changes and to indicate			_			
		taff will document the client's		(d) Monitoring procedure to ensure corre	ection			
		rvation sheet every 15		(a)(2) During daily Administrator on Call re	ounds, the			
	minutes"		i i	AOC will check the 15-minute check sheet				
			With Act of the	evidence of appropriate stickers signifying				
		18 of the facility policy titled		safety precautions that must correspond				
		iewed/revised 12/2016		precautions identified by the High Risk/Hi				
		rsing documentation will		Hand-Off and, as ordered by the patient's	• •			
		ng of accurate, timely data,		Deficiencies noted will be immediately co				
		rrent status of the client, the		The findings will be summarized at the Ho Morning Meeting of leadership staff. The	•			
	•	e progress made by the		will be aggregated and reviewed at the w	_			
		2. Assessment of a client's		PI Committee. A Governing Board Member	•			
		d progress in treatment is an d will be documented by the		weekly participant to hear the results pre-				
-	0 01	ny status changes. 3. The		this meeting. The findings, conclusions,				
	_	summary documentation		recommendations, and actions will be				
		ery seven daysincident		forwarded by the Director of				
		oleted. The weekly/ daily		Quality/Compliance/Risk to the Hospital's	monthly			
		clude the individual response		Quality/PI Council, Medical Executive Con	nmittee and			
	_	fects and relevant lab values.		Governing Board at each of their respecti				
		ncludes any circumstances		meetings. This process will continue as pr	esented on			
		which indicate an immediate		a go-forward basis and has no end date.				
l .								

or unexpected change of status. Some examples

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Root cause (contributing factor): 1/26/18 V 105 Continued From page 7 3) Information of incoming patients and prior include ...injuries, special treatment procedures ... placements with other patients was not always and self-abusive behaviors. 5. Summary known to the facility. History of patterns of elopement and history of violent behaviors were documentation is directed at recording progress toward achieving the measurable treatment plan not always communicated. (a)Part of the guery of the intake assessment now goal. Summary documentation should include compares prior placements of prospective residents ...Client's mental status, physical status, behavior to those residents currently in house. If there is in the therapeutic milieu, mood, affect, medication evidence learned of a prospective resident having compliance and response, appetite and intake, resided at the same facility of a current resident, a percent of weight gain or loss, grooming and further inquiry regarding relationship between the hygiene, quality of sleep, nursing interventions, two will be obtained and documented before current nursing care being provided, and any accepting the new resident. Prospective residents restrictive interventions needed ... 7. Staff will with determined histories of conflict with a current document the client's location on the observation resident or having affiliated with a current resident sheet every 15 minutes ..." will be excluded from admission. Review of a local "Police Department Incident All intake assessment staff are being trained through Report" revealed the police were called on inservice activities on these requirements. In order 01/01/2018 at 2156 to assist with an assault to to remain on the schedule, staff not in attendance MHT #10, property damage and ten missing for the inservice are required to receive training on persons listed as Resident #8 this requirement prior to any scheduled work by the Resident #9 completion date. Resident #10 Resident #2 Resident #1 Staff not meeting these requirements will be Resident #11 Resident #6 addressed on a progressive disciplinary basis. Resident #12 Resident #3 and (b) Date of Completion: Approved by the Governing Resident #7 Board 01/26 /2018 and now in place for PRTF unit A.1. Open medical record review on 01/09/2018 (c) Responsible Person: Chief Executive Officer for Resident #1 revealed a admitted to the Psychlatric Residential Treatment /2017 with diagnoses of Facility (PRTF) on (d) Monitoring procedure to ensure correction 3)(a) All (100%) admissions to the PRTF will be Review of the reviewed by the Admissions Coordinator and intake assessment revealed the resident the CEO for evidence of compliance with this Admission review and application of exclusionary criteria vital signs were for residents with history of conflict or an affiliation with a current resident. Review of the On a weekly basis, SBC, Charlotte will conduct

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Psychiatrist Evaluation documented on

PRINTED: 02/07/2018 FORM APPROVED

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY a PRTF Performance Improvement V 105 V 105 Continued From page 8 (PI)Committee meeting. A Governing Board 2017 at 2050 revealed member will be a weekly attendee. One of the indicators for review will be compliance with the exclusionary criteria. The results will be forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and Governing Board at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date. Further review of the "Admission Intake /2017 stated Assessment Form" dated Root cause (contributing factor): Resident #1 had the following risk and history of 4)The treatment plans did not always reflect 2/18/18 individualized patient information including violence: ' elopement history, violence history, and strategies Based on the to prevent. An audit for same was not in place to identify deficient entries. medical record review there was no evidence (a)(1) All staff with responsibility for completion of available to determine facility staff implemented a the treatment plan ae being instructed through treatment plan to address the history of inservice education on the requirement to include elopement and patterns of violence. Review of all patient information that will be necessary to the medical record revealed documentation of a formulate an effective initial treatment plan for the for Resident #1 on resident. Information shall include elopement and violence history, suicide precautions, and any or from precautions that may impact the resident's safety and the safety of other residents and staff. for and a on Compliance with this responsibility will be evaluated 7 from for daily (M-F) as part of the Hospital's Morning . Review of facility Leadership meeting (see monitoring section for vide recordings on 01/10/2018 of residential description). Deficiencies noted will be updated hally ays on 01/1/2018, revealed Resident #1, within one hour of discovery. Staff not meeting these fully dressed in requirements will be addressed on a progressive disciplinary basis. Review of the record revealed a nursing shift note in order to remain on the schedule, staff not in 01/01/2018 at 2035 that recorded attendance for the inservice are required to receive training on this requirement prior to any scheduled work by the completion date.

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE **CHARLOTTE, NC 28210** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) V 105 V 105 Continued From page 9 Staff not meeting these requirements for use of the treatment plan to individualize the patient's precautions and associated plan of care will be addressed on a progressive disciplinary basis. (b)(1) Date of Completion: 02/18/2018 Record review revealed a 7pm-7am nursing note dated (c)(1) Responsible Person: Director of Clinical 01/01/2018 at 2100 that recorded ' Services a)(2) All staff with responsibility for completion of 2/18/18 the treatment plan have been instructed that with patient events including restrictive interventions, elopement attempts, suicide gestures, aggressive acts, and changes in patient condition, that they are to update the treatment plan to reflect any new precautions and individualized plan of care to ensure the resident's safety and the safety of any other Review of an residents and staff. Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room In order to remain on the schedule, staff not in 01/01/2018. attendance for the inservice are required to receive training on this requirement prior to any scheduled Review of the Observation Sheet dated work by the completion date. 01/01/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review Staff not meeting these requirements for use of the revealed the resident was located at treatment plan to update the patient's precautions and associated plan of care will be addressed on a progressive disciplinary basis. Compliance with this responsibility will be evaluated daily (M-F) as part of the Hospital's Morning Review of the Observation Sheet dated Leadership meeting (see monitoring section). 01/02/2018 revealed every 15 minute checks Deficiencies noted will be updated within one hour were recorded from 0000 through 2345. Review of discovery. Staff not meeting these requirements revealed the resident was located at " will be addressed on a progressive disciplinary basis. Review of the night shift notes recorded by MHT #16 revealed the resident (b)(2) Date of Completion: 02/18/2018 (c) (2) Responsible Person: Director of Clinical Services

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PRINTED: 02/07/2018 FORM APPROVED

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) (d)Monitoring procedure to ensure correction V 105 V 105 Continued From page 10 4) (a) (1 and 2) A 100% audit of treatment plans will occur daily(Monday through Friday with the results of Friday, Saturday, and Sunday incorporated into Monday's report) against the Review of the medical record on 01/09/2018 resident's "High Alert Notification " list and revealed no documentation of a nursing progress notes and incident reports related to assessment in the record after the resident was resident events that have occurred including returned from elopement. Review of the record acts of violence, elopement attempts, suicide on 01/11/2018 revealed a nursing note attempts/gestures, acts of aggression, changes documented by RN #5 dated 01/02/2018 at 0015 in the patient's condition, and any events that that recorded the resident may impact the resident's safety and the safety Note recorded that of other residents and staff. The purpose of the audit will be to assess if the risks were initially captured as part of the treatment plan and if post event, the treatment plan been updated to reflect events or changes in the patient's condition. The findings of this audit will be reported at the Morning Meeting of Hospital Review of nursing note dated 01/02/2018 at 1430 Leadership Staff, Monday through Friday. revealed " These findings will be aggregated and presented on a Review of weekly basis to the newly formed SBC, telephone orders dated 01/02/2018 not timed Charlotte PRTF PI Committee. A Governing revealed orders to place Resident #1 on Board member shall be an attendee of that and to for meeting to hear the results and actions. The and findings, conclusions, recommendations, and actions taken will be forwarded by the Director orders dated 01/02/2018 at of Quality/Compliance/ Risk to the Hospital's 2050 revealed a telephone order for monthly Quality/PI Council, Medical Executive (medication for behavior) Committee and Governing Board at each of as needed for Review their respective meetings. This process will of a Case Management Note documented by the continue as presented on a go-forward basis Director of Clinical Services (DCS), dated and has no end date. 01/02/2018 and signed as "Late Entry" on 01/03/2018 at 1700 revealed she met with the client, the Director of Nursing (DON) and the Milieu Manager (MM) after the resident was returned to the facility

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Note recorded the DCS and the DON questioned

Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Root cause (contributing factor): Meeting V 105 Continued From page 11 V 105 5) The prior CEO had erroneously communicated to With Police client about any injuries, pain or other concerns. staff to not involve the Police in patient situations. 1/17/18 Note recorded the DCS set expectations for resident's return to the unit. Note recorded the (a) All Hospital staff are now receiving training client was assessed by a Registered Nurse (RN). specific to the expectation that the Charlotte Police Trng and Review of the Psychiatrist progress note dated Department is to be called if there is a patient re-trng on situation that is unable to be managed by personnel 01/04/2018 at 1237 revealed ' policy on site. It has been further clarified that the on-site Supervisor or Charge Nurse is empowered to contact 2/18/18 completed the Police Department and does not have to have approval by any off site administrative staff to do so. Attachment "E" delineates this policy that is in effect. A meeting was held with the Charlotte Police Department to discuss the appropriateness of contacting them and to ensure their agreement that in situations that cannot otherwise be handled by staff and that may impact the safety of staff or residents that the police may be contacted for assistance. Review of a Health Incident Review Report for 100% of key events including restrictive Resident #1 completed by RN #2 and dated interventions, aggressive acts of patients to patients 01/01/2018 recorded " and patients to staff, and reports of staff perceptions of lack of adequate staff to handle a patient situation will occur daily (Monday through Friday with the results of Friday, Saturday, and Sunday incorporated into Monday's report) will be reviewed to assess if the Police were contacted, when indicated and, if not, the reasons for same. Re-training and reclarification of the use and contact of the Charlotte Review of the report revealed the date Police Dept. will occur. and time of the elopement was 01/01/2018 at 2155. Staff not meeting these requirements after retraining will be addressed on a progressive Review of a Health Incident Review Report for disciplinary basis. Resident #1 completed by RN #4 on 01/02/2018 recorded "

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) (b) Date of Completion: V 105 V 105 Continued From page 12 Meeting with Charlotte Police Dept.: 01/17/2018 Completion of training on policy for all SBC Charlotte Review of a Health Incident Review Report for Resident #1 completed by RN #5 and dated 02/18/2018 01/02/2018 recorded "( (c) Responsible person: Director of Compliance/Quality/Risk (d) Monitoring procedure to ensure correction 5) Compliance will be monitored as follows: Review of the report revealed A 100% review of key events including restrictive the date and time of the incident was 01/02/2018 interventions, aggressive acts of patients to patients at 1321. and patients to staff, and reports of staff perceptions of lack of adequate staff to handle a patient situation Review of the Medication Administration Record will occur daily (Monday through Friday with the revealed no available documentation of results of Friday, Saturday, and Sunday incorporated administered on 01/02/2018. Review of into Monday's report) to assess if the Police were Restrictive Intervention documentation dated contacted, when indicated. The findings of this 01/02/2018 at 1321 revealed a physician order for review will be reported at the Morning Meeting of for Hospital Leadership Staff, Monday through Friday. Resident These findings will be aggregated and presented on a and weekly basis to the newly formed SBC, Charlotte . Resident PRTF PI Committee. A Governing Board member shall be an attendee of that meeting to hear the Restrictive intervention documentation revealed results and actions. The findings, conclusions, Resident #1 was recommendations, and actions taken will be forwarded by the Director of Quality/Compliance/ 2/2018 at on , then a Risk to the Hospital's monthly Quality/PI Council, and Restrictive Medical Executive Committee and Governing Board Intervention documentation revealed Resident #1 was administered at each of their respective meetings. This process will continue as presented on a goforward basis and has no end date. Interview on 01/12/2018 at 1015 with RN #5 revealed Resident #1 was the resident escorted to room at Resident #1 had a

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01/17/2018

(X3) DATE SURVEY

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL0601258 NAME OF PROVIDER OR SUPPLIER STRATEGIC BEHAVIORAL CENTER-CHARLOTTE SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG V 105 Continued From page 13 Interview on 01/12/2018 at 1015 with RN #5 revealed Resident #1 was admitted to the hall due to elopement risk. Interview revealed Interview revealed we Interview revealed from that point forward Resident #1 and Resident #2 were not to be on the same hall together. 2. Closed medical record review of Resident #2 admitted to the revealed a Psychiatric Residential Treatment Facility (PRTF) /2017 as Review of the record revealed admission diagnosis included Review of admissions information titled "Clinical Evaluation/Diagnostic Assessment" /2017 recorded by a dated revealed Review revealed the resident has Review revealed on the resident

A. BUILDING: COMPLETED

The state of the s

STREET ADDRESS, CITY, STATE, ZIP CODE

PREFIX

TAG

V 105

(X2) MULTIPLE CONSTRUCTION

1715 SHARON ROAD WEST CHARLOTTE, NC 28210

Root cause (contributing factor):

6) There was no prior experience of what evolved into a patient riot or actions to take

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

All elements 2/18/18

COMPLETE DATE

(a) A Riot Management plan was developed by the Hospital. The plan delineates all actions to take in the event of a riot, which is defined as: "an act of imminent threat or violence by approximately three or more persons acting collaboratively to harm staff or other patients, to destroy property, or escape from the unit". Attachment "F" delineates the Riot Management Plan that was developed.

All SBC Charlotte Hospital staff were trained on the requirements of the riot management plan including the expectation to involve the police early should such a patient riot, again, occur. Drills on Riot Management are occurring on a monthly basis at the Hospital.

The Riot Management plan and actions of staff to take has been incorporated into the Hospital's ongoing orientation.

## (b) Date of Completion:

Approved for Implementation: 1/11/2018 Completion of training on Riot Management plan: 2/18/18

Riot management drills in place as of: 2/18/18 Content included in Hospital Orientation as of: 02/18/2018.

(c) Responsible Person: Chief Executive Officer

## (d)Monitoring procedure to ensure correction

 Compliance with implementation of the Riot Management plan, as indicated, will be monitored as follows:

A 100% review of events that meet the Hospital's definition of a patient riot will be reviewed daily (Monday through Friday with the results of Friday, Saturday, and Sunday incorporated into Monday's

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documented by a

(not timed) recorded the resident

STATE FORM

The resident was

on

Comprehensive Psychosocial Assessment Tool

Review of a

V2017

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) report) to assess if the Riot Management plan V 105 V 105 Continued From page 14 was followed including if the Police were contacted, when indicated. The findings of this review will be reported at the Morning Meeting Further review of the "Admission Intake of Hospital Leadership Staff, Monday through Assessment Form" dated 2017 stated Friday. Resident #2 had the following risk and history of These findings will be aggregated and violence: " presented on a " Based on the medical record review weekly basis to the newly formed SBC, there was no evidence available to determine Charlotte PRTF PI Committee. A Governing facility staff implemented a treatment plan to Board member shall be an attendee of that address the history of elopement and patterns of violence. Review of facility video recordings on meeting to hear the results and actions. The findings, conclusions, recommendations, and 01/10/2018 of residential hallways on 01/1/2018 revealed Resident #2, fully dressed in actions taken will be forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Medical Executive Review of admission orders dated Committee and Governing Board at each of revealed the resident was placed on their respective meetings. with every 15 minute observation This process will continue as presented on a checks. Review of an Observation Sheet dated go-forward basis and has no end date. 01/01/2018 revealed the resident was assigned to on 01/01/2018. Review of the Root cause (contributing factor): 1/10/18 Observation Sheet dated 01/01/2018 revealed 7) The windows between units had been frost from every 15 minute checks were recorded from 0000 required by another oversight agency to be windows through 2345. Review revealed the resident was occluded. As a result, staff were unable to see removed located at " (location not defined) from what was occurring behind a hallway door without opening it. (location not defined). Review of the night shift (a) The frosting on the windows has been notes recorded by MHT #14 revealed the resident removed. 2/18/18 all was returned from elopement and placed on All Hospital Staff with patient care every 15 minute room checks. The notes elements responsibilities are being inserviced to look recorded that the resident was given through the window before moving from one unit to another and to not open the door if, in Review of nursing notes documented by RN #2 doing so, patients can spill over into another on 01/01/2018 at 1920 recorded the resident's unit or elope into another area. Staff have also was and was given been instructed to redirect patients that are Notes recorded " seen hovering around doorways or attempting

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other unit.

to look through the window at patients on the

Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY In order to remain on the schedule, staff not in V 105 V 105 Continued From page 15 attendance for the inservice are required to receive training on this requirement prior to any scheduled work by the completion date. Staff not meeting these requirements will be addressed on a progressive disciplinary basis. An "Own the Door" campaign was initiated to encourage staff to remember and respond to this requirement. " Review of the medical This expectation has been incorporated into the record on 01/10/2018 revealed no documentation Hospital's orientation. of a nursing assessment in the record. Review on 01/11/2018 revealed a nursing note Compliance with the process is being evaluated with documented by RN #5 dated 01/02/2018 at 0010 all patient events and as a part of daily monitoring that recorded the resident returned to the facility for compliance with expectations whereby camera Notes recorded the resident was view is observed during the Safety meetings to observe staff's compliance with this safety measure. Staff remaining out of compliance will be addressed through the hospital's progressive disciplinary procedure. ." Record review revealed the resident was (b) Date of Completion: searched and dressed in paper scrubs upon Frosting removed from windows: 1/10/18 return to the facility on 01/02/2018. Review revealed the resident was placed on Education on expectations related to looking through upon return. Review of nursing notes the doorways before entering a patient unit: documented on 01/02/2018 at 1400 recorded 02/18/2018 "Own the door" campaign training completed: 02/18/2018 Review of a psychiatrist progress note dated Camera review process in place as of: 02/18/2018 01/04/2018 at 1242 recorded the patient admitted Content on safety expectations in place in stating that orientation as of: 02/18/2018 Review of the notes revealed (c) Responsible Person: Safety Officer

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Division o	of Health Service Regu	ulation			PORINI APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i:	COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
		1715 SH	ARON ROAD V	VEST	
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE CHARLO	OTTE, NC 2821	0	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
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TAG	REGULATORTOR	LSC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	UAIE DAIL
V 105	Continued From pag	o 17	V 105	In order to remain on the schedule, staff r	ot in
V 100	Continued From pag	6 17	* 100	attendance for the inservice are required	to receive
	treatment plan to add	fress the history of		training on this requirement prior to any s	cheduled
		rns of violence. Review of		work by the completion date.	
	facility video recording			This was a second associated asso	h h
		on 01/1/2018, revealed		This process and associated expectations incorporated into the Hospitals Nursing or	
	Resident #11, fully de	ressed in		meorporated into the Hospitals Natsing of	ientation.
				(b) Date of completion:	
	Review of admission	orders revealed the resident		Discontinuation of the central medication	station for
		15 minutes observation and	medication administration: 02/02/20		3
	•	5 minute observation on			
		of an Observation Sheet		02/18/2018	
	dated 01/01/2018 res	vealed the resident was		(c) Responsible person: Director of Nursi	
	•	on 01/01/2018. Review		(c) Responsible person: Director of Nursi	ng
		neet dated 01/01/2018		(d) Monitoring procedure to ensure of	orrection
	revealed every 15 m			8) On a weekly basis, the Director of Nurs	
		00 through 2345. Review		trained delegate will observe a medication	
	revealed the residen	" from ";		every shift to assess if the requirements re	elated to
	then " fr	rom ; then		medication administration are being follo	
	" from	; then "		including restriction to medication admini	
		" from		confined to each patient's own unit. The	_
	then "	" from		this review will be aggregated and presen weekly basis to the newly formed SBC, Ch	
				PRTF PI Committee. A Governing Board in	
				shall be an attendee of that meeting to he	
		notes recorded by MHT #17		results and actions. The findings, conclusi	
	revealed "			recommendations, and actions taken will	
				forwarded by the Director of Quality/Con	•
				Risk to the Hospital's monthly Quality/PI	•
				Medical Executive Committee and Govern at each of their respective meetings.	ling Board
		." Review of notes		or each of their respective meetings.	
	at 2202 revealed "			This process will continue as presented o	n a go-
				forward basis and has no end date.	
		A sursian sets by DNI #4			
	01/02/2018 at 0000	A nursing note by RN #1 on			
t .	0 1/02/20 10 at 0000	i econded			

Division of Health Service Regulation STATE FORM

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
		1715 SH	ARON ROAD W	EST	
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE CHARLO	OTTE, NC 2821	)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
	Nursing notes docum 01/02/2018 at 1330 rd 2200 recorded the re for evaluation and ref 01/03/2018 at had Notes rev medication was admi note dated 01/02/201 "(  Review of the medication revealed no further dassessment in the re elopement on 01/01/	ented by RN #5 dated ecorded "" Notes at sident was transported to a urned from on Notes revealed the resident and ealed nistered. Review of an LPN 8 at 0050 recorded"  al record on 01/10/2018 ocumentation of a nursing cord after return from 2018. Review on 01/11/2018 ote documented by RN #5	V 105		tents and broken. Jents and reinforced and reinforc
				furniture that appears to have been comp that may pose a possible risk for being bro In order to remain on the schedule, staff r attendance for the inservice are required	oken. not in
1		"···			

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) training on this requirement prior to any scheduled V 105 V 105 Continued From page 19 work by the completion date. (b) Date of Completion: All patient chairs reinforced to prevent being dismantled: 01/09/2018 Desks removed from resident environment and will remain out of patient area until replacement desk is completed: 01/11/2019 Prototype desk devised: 02/07/2018 Closed medical record review of Resident #7 revealed a admitted to the All staff educated about expectation for the use of PRTF on 2017 with the Police to assist, as presented: 02/18 /2018 System for checking status of furniture per rounds in place as of: 02/23/2018 Further review of the "Admission Intake Assessment Form" dated /2017 stated (c) Responsible person: Director of EOC Resident #7 had the following risk and history of (d) Monitoring procedure to ensure correction violence: ' ." Based on the medical record review there was no evidence available to 9) Compliance with the corrective actions will be determine facility staff implemented a treatment accomplished as follows: plan to address the history of elopement and On a daily basis (M-F), the EOC Director will conduct patterns of violence. Review of facility video rounds in all resident care areas to ensure that the recordings on 01/10/2018 of residential hallways furniture is secure, and that there is evidence of no on 01/1/2018, revealed Resident #7, fully dressed tampering with same. On weekends, these rounds will be accomplished by the House Supervisor. These rounds will be augmented by MHT staff who are to Review of admission orders revealed the resident assess the integrity of all furniture in the PRTF patient care areas prior to the start of each shift. was placed on every 15 minutes observation and remained on every 15 minute observation on Any items that appear to have been compromised or 01/01/2018. Review of an Observation Sheet that may pose a possible risk for being broken will be dated 01/01/2018 revealed the resident was immediately removed from the environment and not assigned to Room on 01/01/2018. Review returned until repaired or replaced. of an Observation Sheet dated 01/01/2018 revealed every 15 minute checks were documented from 0000 through 2345. Review revealed the resident was located at 1 from

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from

; then

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE **CHARLOTTE, NC 28210** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Compliance with this process and the findings of this V 105 V 105 Continued From page 20 review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. ; then ' " from These findings, conclusions, and actions taken will be ; then ' aggregated and presented on a from then weekly basis to the newly formed SBC, Charlotte Review of ' from PRTF PI Committee. A Governing Board member Night shift notes recorded by MHT #13 revealed shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, recommendations, and actions taken will be forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and Governing Board at each of their respective meetings. Review of nursing notes documented by RN #1 dated 01/01/2018 at 2015 This process will continue as presented on a gorevealed the resident was forward basis and has no end date. and offered and refused pm (as needed) . Review of notes at 2202 medication Root cause (contributing factor): 2/18/18 revealed ' 10) The medical record audit process was not capturing time/date omissions, assessments and reelements assessments not documented, as required. Similarly, the performance improvement review in place process was not capturing the review for compliance with items including treatment plan ." A nursing note by RN #1 on content against patient precautions and re-01/02/2018 at 0000 recorded ' assessments per expectation. (a) All SBC Charlotte Hospital leadership staff with responsibilities within their departments for medical Review of nursing notes documented by an LPN record documentation have been re-educated on the dated 01/02/2018 at 0130 recorded ' specific requirements for the medical record components including: but not limited to: (1) Dating/timing of orders within requirements (2) Frequency of documentation ." Nursing noted (3) Medications documented as ordered (4) Completion of assessments and reassessments per time requirements Nursing notes documented by RN #5 dated (5) Frequency of MD Progress Notes 01/02/2018 at 1300 recorded (6) Co-signature by MD after Seclusion and Restraint within 24 hours These items are in addition to those otherwise noted Notes at 2200 recorded the resident was in this report. transported to for evaluation and

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) All SBC Charlotte Hospital and Medical staff with V 105 V 105 Continued From page 21 responsibility for documentation have been returned from on 01/03/2018 at reminded through meetings and written memoranda of the requirements for documentation, as Notes revealed the resident had delineated above. and revealed was All SBC Charlotte Hospital leadership staff with administered. Review of the medical record on responsibilities within their departments for medical 01/10/2018 revealed no documentation of a record documentation have been re-educated on the nursing assessment in the record. Review on medical record audit process and associated 01/11/2018 revealed a nursing note documented expectations for its completion. by RN #5 dated 01/02/2018 at 0010 that recorded Staff that remain out of compliance will be addressed through the Hospital's progressive disciplinary process. Medical staff remaining out of compliance will be addressed through the Medical Staff Peer Review process. Record (b) Completion Date: review revealed the resident was discharged on Re-education of Hospital and Medical Staff: 01/03/2018. 02/18/2018 5. Open medical record review of Resident #12 Re-education of Hospital leaders on requirements: revealed a admitted to the 01/31/2018 PRTF on /2017 with Initiation of intensified audits: 02/01/2018 Review of (c) Responsible Person: a Comprehensive Psychosocial Assessment Tool Director of Compliance/Quality/Risk completed by a on /2017 at 1703 revealed the patient had a (d)Monitoring procedure to ensure correction: a) 100% audit of medical records will occur over the course of the week against medical records including Further review of the medical record revealed compliance with: there was no evidence available to determine (1) Dating/timing of all orders facility staff implemented a treatment plan to (2) Frequency of documentation address the history of elopement. Review of (3) Medications documented as ordered facility video recordings on 01/10/2018 of (4) Completion of assessments and reassessments residential hallways on 01/1/2018, revealed per time requirements Resident #12, fully dressed in (5) Frequency of MD Progress Notes (6) Co-signature by MD after Seclusion and Restraint Review of admission orders revealed the resident

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was placed on every 15 minute observations and

6800

within 24 hours

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** The findings of this audit will be reported on, at least, V 105 Continued From page 22 V 105 a weekly basis at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. remained on every 15 minute observation on These findings will be aggregated and presented on a 01/01/2018. Review of an Observation Sheet weekly basis to the newly formed SBC, Charlotte dated 01/01/2018 revealed the resident was assigned to Room on 01/01/2018. Review of PRTF PI Committee. A Governing Board member an Observation Sheet dated 01/01/2018 revealed shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, every 15 minute checks were documented from recommendations, and actions taken will be 0000 through 2345. Review revealed the resident forwarded by the Director of Quality/Compliance/ was located at ' Risk to the Hospital's monthly Quality/PI Council, then ' from fron Medical Executive Committee and Governing Board ; then ' at each of their respective meetings. This process will " from ; then ' continue as presented on a go-forward basis and has " fron no end date. Review of Night shift notes recorded by MHT #16 revealed ' ..." Review of the medical record on 01/10/2018 revealed no documentation of a nursing assessment in the record. Interview on 01/12/2018 at 0955 with RN #5 revealed each resident had a daily observation sheet and the MHT assigned to the resident is responsible for doing the 15 minute observation checks. Interview revealed the 15 minute checks means "eyes on the resident and they know exactly where the resident is, document location and initial." RN #5 stated that the residents that eloped on 01/01/2018 started coming back one at a time around 0000. The nurse stated it took around 30 to 40 minutes to get them all back. RN #5 reviewed observation sheets for Resident #12

resident Division of Health Service Regulation

and stated it was not accurate. The nurse stated it was documented that the resident was in the at 2300, but he didn't return until

wasn't back yet. I don't know why

0000. "She couldn't have laid eyes on the

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 105 Continued From page 23 V 105 she documented that. It isn't correct." 6. Open medical review on 01/11/2018 of Resident #9 revealed a admitted to the PRTF unit on /2017 due to . Review of the Intake Assessment dated 11/06/2017 revealed Resident #9 was at risk for elopement with a history of " ." Review revealed Resident #9 was not placed on elopement precautions on admission. Further review of the medical record revealed there was no evidence available to determine facility staff implemented a treatment plan to address the history of elopement. Review of facility video recordings on 01/10/2018 of residential hallways on 01/1/2018 revealed Resident #2, fully dressed in Review revealed Resident #9 lived on the hall. Review of a nursing note dated 01/01/2018 at 2120 revealed Resident #9 ' . Review of an Observation Sheet dated 01/01/2018 revealed every 15 minute checks were documented from 0000 through 2345. Review of the Q 15 Minute Observation sheet dated 01/01/2018 revealed Resident #9's location from was " " Review revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded "

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 105 Continued From page 24 V 105 ". Review of a physician order dated 01/02/2018 revealed Resident #9 was placed on . Review of the Physician Progress note dated 01/04/2018 revealed Resident #9 was part of the elopement on the unit. Further review of the physician progress note revealed Resident #9 reported " Review revealed Resident #9 stated ' Review on 01/11/2018 of a Health Incident Review Report dated 01/02/2018 revealed Resident #9 eloped from the unit on 01/01/2018 during the 1900 to 0700 by along with other peers. 7. Open medical record review on 01/10/2018 for Resident #10 revealed a admitted to the Psychiatric Residential Treatment Facility (PRTF) from on /2017 with a diagnosis of Review of the nursing notes revealed Resident #10 arrived on the PRTF unit . Review of nursing notes revealed the , with no resident was complaints of pain or discomfort. Review of the nursing notes revealed the resident had old injuries noted to Admission vital signs were

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 105 V 105 Continued From page 25 . Review of the intake assessment revealed the resident was currently . Further review of the intake assessment revealed documentation of elopement risk related Further review of the "Admission Intake Assessment Form" dated 12/22/2017 stated Resident #10 had the following risk and history of violence: 1 ." Based on the medical record review there was no evidence available to determine facility staff implemented a treatment plan to address the history of elopement and patterns of violence. Review of facility video recordings on 01/10/2018 of residential hallways on 01/1/2018 revealed Resident #10, fully dressed in Review of the record revealed a nursing note documented by RN #1 dated 01/01/2018 at 2045 that recorded ' ." Review of the record revealed a note documented by RN #1 dated 01/01/2018 at 2202 that recorded "Review of the record revealed a note documented by RN #1 dated 01/02/2018 at 0000 that recorded ." Review of an Observation Sheet

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dated 01/01/2018 revealed the resident was

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE **CHARLOTTE, NC 28210** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 105 | Continued From page 26 V 105 on 01/01/2018. Review assigned to Room of the Observation Sheet dated 01/01/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at " from , at 2. at from at and at . Review of the from Observation Sheet dated 01/02/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at Review of the night shift notes recorded by MHT #16 revealed the resident ." Review of the medical record on 01/10/2018 revealed no documentation of a nursing assessment in the record. Review of the record on 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at that recorded the resident returned to the facility . Note recorded the resident was ' " Note recorded that ." Review of telephone orders dated 01/02/2018 not timed revealed orders to place Resident #10 on and to land upon return to facility. Review of a Case Management Note documented by the Director of Clinical Services (DCS), dated 01/02/2018 and

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Division of	Health Service Regu	ulation			
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		
		MHL0601258	B. WING		01/17/2018
NAME OF PRO	VIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE	
			IARON ROAD WEST		
STRATEGIC	<b>BEHAVIORAL CENTE</b>	R-CHARLOTTE			
			OTTE, NC 28210		
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	,
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IAG	THE STEET OF THE STEET		ing	DEFICIENCY)	1711
					i .
V 105 (	Continued From page	e 27	V 105		
	signed as "Late Entr	y" on 01/03/2018 not timed			
	•	h the client, the Director of			
		he Milieu Manager (MM)			
3	atter the resident was	s returned to the facility			
	1.11 17.01.1	. Note recorded the DCS			
	-	oned client about any injuries,			
		ns. Note recorded the DCS			
	•	resident's return to the unit.			
1		ient was assessed by a			
	Registered Nurse (R	•			
		s note dated 01/04/2018 at			
	1249 revealed "	السمالية كال			
Ì					
i					
		н			
•					
	Review of a Health I	ncident Review Report for			
	Resident #10 comple	eted by RN #1 and dated			
	01/01/2018 recorded	i "Electrical de la Contraction de la Contractio			
	." Review of the	report revealed the date and			
		nt was 01/01/2018 at 2155.			
	8. Open medical red	cord review of Resident #8			
1	revealed a	admitted to the			
		7 with			
		Review of a Comprehensive			
		sment Tool completed by			
	on	/2017 at 1000 revealed the			
	patient stated, "	f			
		orders revealed the resident			
		15 minutes observation and			
i	piacoa on oron				

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 105 Continued From page 28 V 105 remained on every 15 minute observation on 01/01/2018. Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to on 01/01/2018. Review of an Observation Sheet dated 01/01/2018 revealed every 15 minute checks were documented from 0000 through 2345. Review revealed the resident was located at ' ; then " from ; then from ; then ' then " from ; then " Review of Night shift notes recorded by MHT #13 revealed " Review of nursing notes documented by RN #1 dated 01/01/2018 at 2030 revealed the resident was involved in and redirected by staff multiple times. Review of notes at 2202 revealed ' A nursing note by RN #1 on 01/02/2018 at 0000 recorded

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Review of the medical

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		01/17/2018
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	
		1715 SH	ARON ROAD WEST		
IKAIEG	IC BEHAVIORAL CENTE	CHARLO	OTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLET
V 105	Continued From pag	e 29	V 105		
	record on 01/10/2018 of a nursing assessm on 01/11/2018 revea documented by RN # that recorded "(	3 revealed no documentation nent in the record. Review			
		ncident Review Report for 1/01/2018 at 2155 revealed			
		"		·	
	o1/09/2018 revealed admitted to the PRT revealed the admiss dated 01/01/2018 tir "Nursing Shift Note. intervention on 01/0 revealed Resident #	F on 1/2017 as a Review of the record ion diagnosis was Review of a nursing note med at 1031 revealed a blank Review of a restrictive 1/2018 from 1/2018 to			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 105 Continued From page 30 V 105 " Review of the Observation Sheet dated 01/01/2018 revealed from 1800-2345 Resident #3 Review of the MHT note on 01/01/2018 revealed "... Review of a telephone physician order dated 01/02/2018 not timed revealed " Review of the medical record on 01/09/2018 revealed no documentation of a nursing assessment on 01/01/2018 in the record. Review on 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at 0015 that recorded the resident returned to the facility . Notes recorded revealed Resident #3 was " Review of a "Therapy Services Note" written on 01/03/2018 at 1132 revealed "

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•	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED
		MHL0601258			01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	
	IO DELLAMODAL OFFITE	1715 SH	ARON ROAD WEST		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
V 105	Continued From page	e 31	V 105		
			1		
		<b>"</b>			,
	10 Closed medical	ecord review on 01/09/2018			
	of Resident #6 revea				
		on /2017 due to			
	severe behavioral pro	oblems and violence.			
	Resident #6 was	10040 Parismakh			
	) on	/2018. Review of the ission diagnoses included			
	record revealed adm	ission diagnoses included			
		Minute Observation Sheet			
		vealed Resident #6 lived on			
		of the Observation Sheet vealed every 15 minute			
		ed from 0000 through 2345.			
		resident was located at "			
	н	from			
	; and	" from			
		ne night shift notes recorded			
	by MHT #16 reveale	d the resident was			
		". Review of the medical			
		8 revealed no documentation			
		nent in the record. Review			
	on 01/11/2018 revea				
		#5 dated 01/02/2018 at 0010 sident returned to the facility			
		orded the resident was			
	11000100	h			

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 105 V 105 Continued From page 32 ." Review of physician order dated 01/02/2018 revealed an order to place the resident on and to be d and s upon return. Review of a nursing note documented by The root causes (contributing factors) of RN #1 dated 01/01/2018 at 2202 revealed the deficiencies in systems identified, and resident " for each: Review of nursing notes documented on a)The procedure for implementing the 01/02/2018 at 0000 recorded resident returned to acceptable plan of correction for the no apparent injuries and was placed on specific deficiency cited; b)The date by which all corrective action will be completed, and the monitoring In summary, facility staff failed to communicate system will be in place. resident's patterns of elopement for seven of ten c) The title of the person responsible for residents and history of violent behaviors for ten implementing the acceptable plan of of ten residents to care staff, failed to implement policies and elopement precautions thereby correction creating an unsafe environment for the delivery of d)The monitoring procedure to ensure that safe resident care. As a result, residents the plan of correction is effective, and that destroyed wooden furniture and made weapons specific deficiency cited remains corrected which placed residents and staff in an unsafe and/or in compliance with the regulatory environment. Subsequently, ten residents eloped from the facility. requirements. V 115 .0208 (A-E) Client Services V 115 V115 0208 (A-E) Client Services Failure of facility staff to supervise and 10A NCAC 27G .0208, CLIENT SERVICES provide a safe environment for the delivery (a) Facilities that provide activities for clients shall of care to adolescent behavioral health assure that: residents. (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, Please note that "Attachment G" captures and treatmenthabilitation needs of the clients the review of items that is now being served; and accomplished as part of the morning (3) clients participate in planning or determining meeting to monitor improvement in all areas needing corrective action: (h) Facilities or programs designated or described

Division	of Health Service Regu	lation				
_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE S COMPL	
		MHL0601258	B. WING		01/1	7/2018
		OTDEST 1	DDDCCC 017/ 0	TATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, S			
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	ARON ROAD V OTTE, NC 2821			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDE DEFICIENCY)	D BE	(X5) COMPLETÉ DATE
V 115	Continued From page	23	V 115	Root cause (contributing factor):	in the second	
V 110	Continued From page	3 33	•	1) Lack of a verbal hand-off process to re	port intake	2/18/18
	in these Rules as "24	-hour" shall make services		assessment information on incoming pa	tients.	_,,
	available 24 hours a	day, every day in the year.		Subsequently, history of patterns of elop	pement,	
	unless otherwise spe	cified in the rule.		history of violent behaviors, and even p		
	` '	e or prepare meals for		residential placement among patients w	as not	
	clients shall ensure the	nat the meals are nutritious.		always communicated.		
	` '	have a physical handicap				
	are transported, the	ehicle shall be equipped		(1)(a) (1) A hand-off form and formalized	•	1
	with secure adaptive	equipment.		have been developed for implementation		
	1 /	e preschool children who		Charlotte, whereby, before a patient is re nursing unit from the intake admission a		
		ance with boarding or riding		Intake Assessor will verbally speak to the	-	
		ported in the same vehicle,		nurse to communicate an overview of th		
		lult, other than the driver, to		history, condition, and all precautions. T	•	
	assist in supervision	of the children.		precautions shall be written on the form		
				"High Risk/High Alert Hand-off" and mus		
	This Rule is not met	as avidopaed by:		to the receiving nurse for their acknowle	dgement	
		ew, medical record review,		and signature of same. The Unit nurse, ir	turn, will	
		report review, Code Purple		be responsible for implementing all orde		
		nterview, facility staff		processes that accompany the specific p		
	•	se and provide a safe		Attachment "H" delineates the hand-off		
		delivery of care to adolescent		policy for its use. During daily Administra		
		sidents for 10 of 10 sampled		rounds, the AOC will check the 15-minut sheets for evidence of appropriate sticke		
		i (#1, #2, #11, #7, #12, #9,		patient safety precautions that must cor		
	#10, #8, #3, and #6)			with those precautions identified by the	•	
				Risk/High Alert Hand-Off and, as ordered	_	
	The findings include	d:		patient's physician.		i
	Review on 01/09/20	18 of policy title "Code		Deficiencies noted will be immediately c	orrected.	
		d/Revised 12/2016 revealed		All intake assessment staff and nursing s		1
	•	identify steps to be utilized in		patient care responsibilities are being tra		
	the event of a Code			through inservice activities on these req		
		roup of RAs will be identified				
		part of the Code Purple		In order to remain on the schedule, staff		
	Team 3. When a	staff member notes that a		attendance for the inservice are require		
	resident is exhibiting	signs of escalated behavior		training on this requirement prior to any	scheduled	
	-	vill be announced over the		work by the completion date.		
		location attached to the				
		ple team members will arrive				
		cation and take direction and				
	cues from the prima	ry staff member on the scene				

STATE FORM

Division of H	ealth Service Regu	lation			<b></b>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CO	DRRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL0601258	B. WING		01/17/2018
					VII.172010
NAME OF PROVI	IDER OR SUPPLIER	STREETAL	ODRESS, CITY, ST	TATE, ZIP CODE	
CTDATECIC D	ENAVIODAL CENTE	1715 SHA	ARON ROAD W	/EST	
STRATEGICE	EHAVIORAL CENTE	CHARLO	TTE, NC 2821	0	
(X4) ID	SUMMARYSTA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	,
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	WATE ,DATE
V 115 Co	ontinued From page	e 34	V 115	Staff not meeting these requirements for	use of the
	9 The primary sta	ff member on the team will		hand -off form and procedure will be add	
		with the RN to de-escalate		a progressive disciplinary basis.	
	•	ed on the level of danger to			
		ry staff and RN will cue the		(b) (1) Date of Completion: 02/18/2018	
		embers into position if there			
	•	restrictive intervention"		(c)(1) Responsible Person: Director of Ad and Referral	missions
R	nyiew on 01/00/201	8 of the hospital's policy and			
		ic Residential Treatment		(d) Monitoring procedure to ensure corre	ection
•	•	24/2015 revealed " Staff			
		st two direct care staff		1)(a)(1) During daily Administrator on Call	rounds,
•	•	esent with every six children		the AOC will check the 15-minute check s	neets for
	adolescents in resi			evidence of appropriate stickers signifying	
01	addicacenta in rea	derida drit.		safety precautions that must correspond	
R	eview on 01/09/201	8 of policy title "Position		precautions identified by the High Risk/Hi	-
		ed Nurse" Date Approved:		Hand-Off and, as ordered by the patient's	• •
	1/31/2015 revealed			Deficiencies noted will be immediately co	
	urseMay assume			100% of patient admissions will be review	
	•	assigned licensed nursing		weekly SBC Charlotte PRTF PI Committee review for compliance with use of the "Hi	-
Į.	,	i.e. assignments, monitoring		Risk/High Alert Hand-Off form. A Govern	· .
	•	v-through and high acuity		Member will be a weekly participant to h	•
1		respond and actively		results presented at this meeting.	: -114
i .	articipate in a psych			F	
'		utic Milieu 2. High visibility		The findings, conclusions, recommendation	ons, and
		ity and takes an active role		actions will be forwarded by the Director	of
w	ith indicated interve	entions"		Quality/Compliance/Risk to the Hospital's	monthly
				Quality/PI Council, Medical Executive Cor	nmittee and
R	eview on 01/10/201	18 of the facility policy titled		Governing Board at each of their respecti	ve
		d/revised on 12/2016		meetings.	
		tain a safe and secure			
		r all clients receiving inpatient		This process will continue as presented o	n a go-
		e: 1. in the event of an		forward basis and has no end date.	
		, 'CODE GREEN' and			
		unced over the intercom. 2.			
		epartment immediately. Give			
1		. Have a description of the			
		ne, height, weight, sex, and			
	•	e arrive give a copy of the			
1		t from the chart. 3. The RN			
W	rill immediately noti	fy the client's physician, the		1	

Division o	Division of Health Service Regulation							
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		MHL0601258	B. WING		01/17/2018			
		WITE COUTE 250			01/1//2010			
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE				
ATE :	10 BELLAVIOR + 1 0=	1715 SH	ARON ROAD W	/EST				
STRATEG	IC BEHAVIORAL CENTE	CHARLO	TTE, NC 2821	· · · · · · · · · · · · · · · · · · ·				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE			
V 115	Continued From page	e 35	V 115	1) (a)(2) A patient safety notification system developed whereby all patients on the system of the s	-,,			
	Medical Director, the	Administrator on Call, and		having identification stickers that are colo	1			
		dian6. When the resident		with level of precautions placed on their 1				
		notify the physician for a		round sheets. According to this system, b				
		ther the resident is to be		their identified safety need, patients will h				
		ergency Department prior to		yellow, green, or white level of precaution	·			
		7. The client will immediately		For example, patients on elopement preca	autions will			
	•	ent precautions and the		be identified on their 15-minute check she	eet as such			
	•	vill be consulted for any		and staff must ensure that they adhere to	all			
	further orders."			provisions of the Elopement policy includi	ng			
				restriction on outdoor activities, as ordere	ed by the			
	Review on 01/10/201	18 of the facility policy titled		patient's physician.	_			
		ons" reviewed/revised		Attachment "I" delineates the new proces	s for			
	12/2016 revealed "	Residents who talk of		patient safety notification.	11-105			
	running away, partici	pate with or know of a		During daily Administrator on Call rounds,				
	planned runaway or	actually run away will be		will check the 15-minute check sheets for				
	placed on elopement	precautionsProcedure		of appropriate stickers signifying patient s precautions that must correspond with the				
	2. The adolescent	who returns from an		precautions that must correspond with the precautions identified by the High Risk/Hi				
	elopement must write	e a detailed narrative		Hand-Off and, as ordered by the patient's	•			
	describing the event	s prior to the run, the run		Deficiencies noted will be immediately co				
	itself, and what trans	pired while the resident was		Staff not meeting these requirements will				
	away. This narrative	must complete prior to the		addressed on a progressive disciplinary ba				
	client being removed	l from elopement		•				
	precautions. The nar	rative should include an		All intake assessment staff and nursing sta	aff with			
	effort to discover an	alternative manner of coping,		patient care responsibilities are being trai	ned			
	_	way. 3. Adolescents on		through inservice activities on these requ	irements.			
		ns will have a bedtime of		In order to remain on the schedule, staff				
	, , ,	Adolescents will be		attendance for the inservice are required				
		ers to use as footwear. No		training on this requirement prior to any	scheduled			
	-	ed. 5. Residents will not be		work by the completion date.				
		unit. 6. The individual's		Staff not mosting these requirements for	use of the			
	•	e modified to reflect the		Staff not meeting these requirements for sticker system procedure will be addresse				
		sary to maintain safety, i.e.		progressive disciplinary basis.	u on a			
		mited phone calls. 7. A		progressive discipitibility basis.				
		l be required to remove the		(b) (1) Date of Completion: 02/18/2018				
		nent precautions. 8. Criteria		(-, (-)				
		m elopement precautions						
		us behavior to self or others,		(c) (2) Responsible Person: Director of N	ursing			
		ious behavior, compliance			•			
		ns, the willingness to talk with						
	staff regularly about	concerns/reelings."						

Division of	of Health Service Requi	lation				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		MHL0601258	B. WING		01/17	/2018
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
			ARON ROAD V			
STRATEG	C BEHAVIORAL CENTEI	R-CHARLOTTE	TTE, NC 2821			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	RTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 115	Continued From page	36	V 115	(d) Monitoring procedure to ensure of	orrection	
	Review on 01/11/2018 "Admission Procedure 12/2016 revealed " itemized on the belon unit C. Patient may reasonable amount or contraband and safet drawstrings and other will not be allowed 'Review on 01/12/201 "Fifteen Minute Check reviewed/revised 12/2 client is observed at minutes by a designation for safety, behavioral client location 5. Stocation on the obserminutes "  Review on 01/12/201 "Documentation" reviewealed "Policy: Nur facilitate the recording which reflects the cur care provided, and he	8 of the facility policy titled es" reviewed/revised B. Belongings are to be ging list when brought to the keep at bedside a f clothing after a thorough y search. Clothing with r potentially hazardous items  8 of the facility policy titled ks / Intervention Log" 2016 revealed "Policy The minimum, every fifteen ted staff member to monitor changes and to indicate aff will document the client's		1) (a)(2) During daily Administrator on Calithe AOC will check the 15-minute check shevidence of appropriate stickers signifying safety precautions that must correspond uprecautions identified by the High Risk/High Hand-Off and, as ordered by the patient's Deficiencies noted will be immediately conthe findings will be summarized at the Homoning Meeting of leadership staff. The will be aggregated and reviewed at the well Committee. A Governing Board Membeweekly participant to hear the results prethis meeting. The findings, conclusions, recommendations, and actions will be forwarded by the Director of Quality/Compliance/Risk to the Hospital's Quality/PI Council, Medical Executive Comfoverning Board at each of their respectimentings.  This process will continue as presented of forward basis and has no end date.  Root cause (contributing factor):  2) The treatment plans did not always reindividualized patient information include elopement history, violence history, and to prevent. A treatment plan audit for sa	neets for spatient with those gh Alert physician. rrected. spital's findings eekly PRTF er will be a sented at monthly nmittee and we n a go-	
	current condition and ongoing process and	progress in treatment is an will be documented by the		not in place to identify deficient entries.  2)(a)(1) All staff with responsibility for co	mpletion of	
	Nurse will document will be completed ever charting will be completed in the complete of the charting in the charting in the charting in the client, we or unexpected change.	ny status changes. 3. Thesummary documentation ery seven daysincident oleted. The weekly/ daily dude the individual response fects and relevant lab valuesncludes any circumstances which indicate an immediate ge of status. Some examples ecial treatment procedures		the treatment plan are being instructed or requirement to include all patient informable by the necessary to formulate an effective plan for the resident. Information shall in elopement and violence history, suicide pand any precautions that may impact the safety and the safety of other residents a	in the ation that e treatment include irecautions, resident's	

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 115 V 115 Continued From page 37 All staff with responsibility for the completion of the treatment plan are being trained through inservice and self-abusive behaviors. 5. Summary activities on these requirements. In order to remain documentation is directed at recording progress on the schedule, staff not in attendance for the toward achieving the measurable treatment plan inservice are required to receive training on this goal. Summary documentation should include requirement prior to any scheduled work by the .Client's mental status, physical status, behavior completion date. in the therapeutic milieu, mood, affect, medication compliance and response, appetite and intake, Staff not meeting these requirements for percent of weight gain or loss, grooming and individualization of the treatment plan with these hygiene, quality of sleep, nursing interventions, patient precautions will be addressed on a current nursing care being provided, and any progressive disciplinary basis. restrictive interventions needed ...7. Staff will document the client's location on the observation Compliance with this responsibility will be evaluated sheet every 15 minutes ..." daily (M-F) as part of the Hospital's Morning Leadership meeting (see monitoring section for Review of a local "Police Department Incident description). Deficiencies noted will be updated Report" revealed the police were called on within one hour of discovery. Staff not meeting these 01/01/2018 at 2156 to assist with an assault to requirements will be addressed on a progressive MHT #10, property damage and ten missing disciplinary basis. persons listed as Resident #8 Resident #9 (b)(1) Date of Completion: 02/18/2018 Resident #2 Resident #10 Resident #1 (c)(1) Responsible Person: Director of Clinical Resident#6 Resident #11 Services Resident #12 Resident #3 and 2) (a)(2) All staff with responsibility for completion of 2/18/18 Resident #7 the treatment plan are being instructed that with A.1. Open medical record review on 01/09/2018 patient events including restrictive interventions, for Resident #1 revealed a elopement attempts, suicide gestures, aggressive acts, and changes in patient condition that they are admitted to the Psychiatric Residential Treatment 2017 with diagnoses of to update the treatment plan to reflect any new Facility (PRTF) on precautions and individualized plan of care to ensure the resident's safety and the safety of any other Review of the residents and staff. intake assessment revealed the resident had a Admission All staff with responsibilities for treatment plans are vital signs were being trained through inservice activities on these requirements. In order to remain on the schedule, Review of the staff not in attendance for the inservice are required Psychiatrist Evaluation documented on

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/2017 at 2050 revealed "...

Division of	of Health Service Regu	ation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0601258	B. WING		01/17/2018	
NAME OF PE	ROVIDER OR SUPPLIER	STREETAD	DDRESS, CITY, ST	TATE, ZIP CODE		
CTRATEC	IC BEHAVIORAL CENTE	D.CHARLOTTE 1715 SHA	RON ROAD W	EST		
SIRALEG	IO BERAVIORAL CENTE	CHARLO	TTE, NC 2821	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
V 115	Continued From page	38	V 115	to receive training on this requirement prints cheduled work by the completion date.	or to any	
	medical record review available to determin treatment plan to add elopement and patte the medical record resistant for Resistant for Resistant for I, a 8 for 1/2017	Based on the withere was no evidence of facility staff implemented a dress the history of the residence of t		Staff not meeting these requirements for treatment plan to update with patient pre will be addressed on a progressive discipling the daily (M-F) as part of the Hospital's Mornit Leadership meeting (see monitoring section Deficiencies noted will be updated within of discovery. Staff not meeting these requirements of the addressed on a progressive discipling (b)(2) Date of Completion: 02/18/2018  (c) (2) Responsible Person: Director of Clistorices  (d) Monitoring procedure to ensure correctly and the services  (d) Monitoring procedure to ensure correctly and the services of the resident's "Notification" list and progress notes and reports related to resident events that has occurred including acts of violence, eloperatempts, suicide attempts/gestures, acts aggression, changes in the patient's conditation and the safety of other residents and staff. The of the audit will be to assess if the risks we captured as part of the treatment plan an event, the treatment plan been updated the events or changes in the patient's conditionings of this audit will be reported at the Meeting of Hospital Leadership Staff, Monthrough Friday.	evaluated and and and and and and and and and an	

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) These findings will be aggregated and presented on a V 115 V 115 Continued From page 39 weekly basis to the newly formed SBC, Charlotte PRTF PI Committee. A Governing Board member shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, recommendations, and actions taken will be Record forwarded by the Director of Quality/Compliance/ review revealed a 7pm-7am nursing note dated Risk to the Hospital's monthly Quality/PI Council, 01/01/2018 at 2100 that recorded Medical Executive Committee and Governing Board at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date. Root cause (contributing factor): 3) The medical record audit process was not capturing time/date omissions, assessments and re-  $^{2/18/18}$ assessments not documented, as required. Similarly, the performance improvement review process was not capturing the review for ." Review of an compliance with items Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room a) In response: 01/01/2018. All SBC Charlotte Hospital leadership staff with responsibilities within their departments for medical Review of the Observation Sheet dated record documentation are being re-educated 01/01/2018 revealed every 15 minute checks through meetings and written memoranda on the were recorded from 0000 through 2345. Review specific requirements for the medical record revealed the resident was located at " components including: but not limited to: (1) Dating/timing of orders within requirements through 2130, at 30. Other: (2) Frequency of documentation (3) Medications documented as ordered (4) Completion of assessments and reassessments Review of the Observation Sheet dated per time requirements 01/02/2018 revealed every 15 minute checks (5) Frequency of MD Progress Notes (6) Co-signature by MD after Seclusion and Restraint were recorded from 0000 through 2345. Review revealed the resident was located at ' within 24 hours Review of the night shift These items are in addition to those otherwise notes recorded by MHT #16 revealed the resident noted in this report. was All SBC Charlotte Hospital and Medical staff with responsibility for documentation are being re-educated through meetings and written

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V3NZ11

memoranda of the requirements for documentation, as delineated above.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) BF TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIE All SBC Charlotte Hospital leadership staff V 115 V 115 Continued From page 40 with responsibilities within their departments for medical record documentation have been re-educated on the medical record audit Review of the medical record on 01/09/2018 process and associated expectations for its revealed no documentation of a nursing completion. assessment in the record after the resident was returned from elopement. Review of the record Staff that remain out of compliance will be on 01/11/2018 revealed a nursing note addressed through the Hospital's progressive documented by RN #5 dated 01/02/2018 at 0015 disciplinary process. Medical staff remaining that recorded the resident returned to the facility out of compliance will be addressed through Note recorded that the Medical Staff Peer Review process. (b) Completion Date: Re-education of Hospital and Medical Staff: 02/18/2018 Re-education of Hospital leaders on requirements: 01/31/2018 Review of nursing note dated 01/02/2018 at 1430 revealed ' Initiation of intensified audits: 02/01/2018 )." Review of (c) Responsible Person: telephone orders dated 01/02/2018 not timed Director of Compliance/Quality/Risk revealed orders to place Resident #1 on s for y and t (d) Monitoring procedure to ensure correction upon return to and facility. a) A 100% audit of medical records will occur over the course of the week against medical records Review of physician orders dated 01/02/2018 at including compliance with: 2050 revealed a telephone order for (1) Dating/timing of all orders (medication for behavior) (2)) Frequency of documentation as needed for (3) Medications documented as ordered of a Case Management Note documented by the (4) Completion of assessments and reassessments Director of Clinical Services (DCS), dated per time requirements 01/02/2018 and signed as "Late Entry" on (5) Frequency of MD Progress Notes 01/03/2018 at 1700 revealed she met with the (6) Co-signature by MD after Seclusion and client, the Director of Nursing (DON) and the Restraint within 24 hours Milieu Manager (MM) after the resident was returned to the facility Note recorded the DCS and the DON questioned client about any injuries, pain or other concerns.

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) The findings of this audit will be reported on, at least, V 115 Continued From page 41 V 115 a weekly basis at the Morning Meeting of Hospital Note recorded the DCS set expectations for Leadership Staff, Monday through Friday. resident's return to the unit. Note recorded the These findings will be aggregated and presented on a weekly basis to the newly formed SBC, Charlotte client was assessed by a Registered Nurse (RN). Review of the Psychiatrist progress note dated PRTF PI Committee. A Governing Board member shall be an attendee of that meeting to hear the 01/04/2018 at 1237 revealed " results and actions. The findings, conclusions, recommendations, and actions taken will be forwarded by the Director of Quality/Compliance/ П Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and Governing Board at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date. 1/10/18 4) Root cause (contributing factor): Transition between units sharing mutual space was Frosting not consistently being assessed before moving removed patients from one area to another. This was attributed to the windows being frosted to prevent patients from viewing one another on opposing Review of a Health Incident Review Report for 2/18/18 Resident #1 completed by RN #2 and dated All Hospital Staff with patient care responsibilities Staff trng 01/01/2018 recorded " are being inserviced to look through the window in all before moving from one unit to another and to not elements open the door if, in doing so, patients can spill over completed into another unit or elope into another area. Staff have also been instructed to redirect patients that are seen hovering around doorways or attempting to look through the window at patients on the other " Review of the report revealed the date In order to remain on the schedule, staff not in attendance for the inservice are required to receive and time of the elopement was 01/01/2018 at 2155. training on this requirement prior to any scheduled work by the completion date. Review of a Health Incident Review Report for Staff not meeting these requirements will be Resident #1 completed by RN #4 on 01/02/2018 addressed on a progressive disciplinary basis. recorded " An "Own the Door" campaign was initiated to encourage staff to remember and respond to this

Division of Health Service Regulation STATE FORM requirement.

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<b>3</b> :	COMPLETED			
		and the second s						
		*****	B. WING		0414710040			
		MHL0601258			01/17/2018			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE				
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(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD)	Ç/			
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	X TAG	CROSS-REFERENCED TO THE APPROPR				
		-		DEFICIENCY)				
	0	- 40	V/ 44 F	This expectation has been incorporated into	o the			
V 115	Continued From page	e 42	V 115	Hospital's orientation.				
		H		•				
	Review of a Health In	ncident Review Report for		Compliance with the process is being evalu	ated with			
		ed by RN #5 and dated		all patient events and as a part of daily mor				
	01/02/2018 recorded			compliance with expectations whereby can	•			
	0 1/02/2010 Tecorded			is observed during the Safety meetings to o				
-				staff's compliance with this safety measure				
				The state of the s				
				Staff remaining out of compliance will be a	ddressed			
				through the hospital's progressive disciplin				
		and any of the same day and		procedure.	,			
		Review of the report revealed		F 30E. G.				
		the incident was 01/02/2018		(b) Date of Completion:				
	at 1321.			Frosting removed from windows: 1/10/18				
	D = d = w = 60 = 64 = 0	Administrative December						
		ation Administration Record		Education on expectations related to looking	ng through			
	revealed no available			the doorways before entering a patient un				
	administered on 01/0			02/18/2018				
		on documentation dated						
		evealed a physician order for		"Own the door" campaign training comple	ted:			
	for			02/18/2018				
				Camera review process in place as of: 02/1	8/2018			
				Content on safety expectations in place in	orientation			
		on documentation revealed		as of: 02/18/2018				
	Resident #1 was pla							
	on 01/02/2018 a			(c) Responsible Person:				
	at and			Safety Officer				
		ntation revealed Resident #1						
	was administered			(d) Monitoring procedure to ensure corre				
	at			4) On a daily basis, during the Safety meet				
				doorways of all PRTF nursing units will be a				
	Interview on 01/12/2	018 at 1015 with RN #5		per camera on a Monday through Friday b				
	revealed Resident#	1 was the last resident		the results of Friday, Saturday, and Sunday				
	escorted to room	at 0 Resident #1 had a		incorporated into Monday's report) to ass				
	:			are looking through the windows before e	_			
	No.			patient units. The findings of this review w				
				reported at the Morning Meeting of Hospi	tal			
	The second secon			Leadership Staff, Monday through Friday.				
	Interview on 01/12/2	018 at 1015 with RN #5						
		1 was admitted to the						

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE **CHARLOTTE, NC 28210** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) These findings will be aggregated and presented on a V 115 V 115 Continued From page 43 weekly basis to the newly formed SBC, Charlotte PRTF PI Committee. A Governing Board member hall due to elopement risk. Interview revealed we shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, recommendations, and actions taken will be forwarded by the Director of Quality/Compliance/ Interview revealed we Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and Governing Board at each of their respective meetings. This process will continue as presented on a go-Interview revealed from that point forward basis and has no end date. forward Resident #1 and Resident #2 were not to be on the same hall together. Root cause (contributing factor): 5 )False perception by staff that the police could not  $^{01/\ 17\ /2018}$ 2. Closed medical record review of Resident #2 Meeting with be called to assist when staff was not, otherwise, revealed a admitted to the police able to obtain control of the residents. Psychiatric Residential Treatment Facility (PRTF) /2017 as (a) All Hospital staff are now receiving training Review of the record revealed admission 02/18 /2018 through inservice education specific to the diagnosis included Completion expectation that the Charlotte Police Department is on trng on to be called if there is a patient situation that is policy unable to be managed by personnel on site. Review of admissions information titled It has been further clarified that the on-site "Clinical Evaluation/Diagnostic Assessment" Supervisor or Charge Nurse is empowered to contact /2017 recorded by dated the Police Department and does not have to have revealed approval by any off site administrative staff to do so (as previously noted in Attachment "E"). Review revealed the resident In order to remain on the schedule, staff not in Review attendance for the inservice are required to receive revealed on /2017 the resident training on this requirement prior to any scheduled work by the completion date. A meeting was held with the Charlotte Police Department to discuss the appropriateness of The resident was Review of a contacting them and to ensure their agreement that in situations that cannot otherwise be handled by Comprehensive Psychosocial Assessment Tool staff and that may impact the safety of staff or documented by /2017 on residents that the police may be contacted for (not timed) recorded the resident assistance.

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE **CHARLOTTE, NC 28210** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY 100% of key events including restrictive V 115 V 115 Continued From page 44 interventions, aggressive acts of patients to patients and patients to staff, and reports of staff perceptions Further review of the "Admission Intake Assessment Form" dated /2017 stated of lack of adequate staff to handle a patient situation will occur daily (Monday through Friday with the Resident #2 had the following risk and history of violence: \* results of Friday, Saturday, and Sunday incorporated into Monday's report) will be reviewed to assess if Based on the medical record review the Police were contacted, when indicated and, if there was no evidence available to determine not, the reasons for same. Re-training and facility staff implemented a treatment plan to reclarification of the use and contact of the Charlotte address the history of elopement and patterns of Police Dept. will occur. Staff not meeting these violence. Review of facility video recordings on requirements after re-training will be addressed on a 01/10/2018 of residential hallways on 01/1/2018 progressive disciplinary basis. revealed Resident #2, fully dressed in (b) Date of Completion: Meeting with Charlotte Police Dept.: 01/17/2018 Review of admission orders dated 12/19/2017 Completion of training on policy: 02/18/2018 revealed the resident was placed on assault precautions with every 15 minute observation (c) Responsible Person: Director of checks. Review of an Observation Sheet dated Quality/Compliance/Risk 01/01/2018 revealed the resident was assigned to on 01/01/2018. Review of the (d) Monitoring procedure to ensure correction Observation Sheet dated 01/01/2018 revealed 5) Compliance will be monitored as follows: every 15 minute checks were recorded from 0000 A 100% review of key events including restrictive through 2345. Review revealed the resident was interventions, aggressive acts of patients to patients located at 1 " (location not defined) from and patients to staff, and reports of staff perceptions of lack of adequate staff to handle a patient situation. will occur daily (Monday through Friday with the (location not defined). Review of the night shift results of Friday, Saturday, and Sunday incorporated notes recorded by MHT #14 revealed the resident into Monday's report) to assess if the Police were was returned from elopement and placed on contacted, when indicated. The findings of this every 15 minute room checks. The notes review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. recorded that the resident was given These findings will be aggregated and presented on a weekly basis to the newly formed SBC, Charlotte Review of nursing notes documented by RN #2 PRTF PI Committee. A Governing Board member on 01/01/2018 at 1920 recorded the resident's shall be an attendee of that meeting to hear the and was given results and actions. The findings, conclusions, Notes recorded recommendations, and actions taken will be forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and Governing Board at each of their respective meetings.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID PREFIX COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Root cause (contributing factor): 2/18/18 V 115 V 115 Continued From page 45 6) Lack of questioning by staff of residents who were wearing multiple layers of clothing or who had torn and handmade bandanas (including one patient who reportedly had an actual bandana). (a) Patients will now have a limit of three changes of clothes at a time in their rooms and the remainder of items will be stored in their patient belongings area (Attachment "j"). (b)Staff have been apprised through Elopement Review of the medical training that an indication of an impending record on 01/10/2018 revealed no documentation elopement is that sometimes the resident is wearing of a nursing assessment in the record. Review multiple layers of clothes or dresses in sneakers or on 01/11/2018 revealed a nursing note shoes when they normally do not do so. documented by RN #5 dated 01/02/2018 at 0010 (c )Staff have been inserviced through classroom and that recorded the resident returned to the facility written memoranda on their need to query residents . Notes recorded the resident was who are noted to be wearing multiple layers of clothing and/or exhibit a change in their practice of items they typically wear and approach them on (b)Date of Completion: Policy change implemented 02/18/.2018 Record review revealed the resident was and dressed in Monitoring for compliance: return to the facility on 01/02/2018. Review 02/18/2018 revealed the resident was placed on s upon return. Review of nursing notes documented on 01/02/2018 at 1400 recorded (c) Responsible person: Director of Nursing (d )Monitoring procedure to ensure correction Review of a psychiatrist progress note dated 6) Compliance will be monitored as follows: 01/04/2018 at 1242 recorded the patient admitted As part of the daily unit rounds on the day and evening shifts, the Director of Nursing or trained delegate will assess patients for the presence of stating tha multiple layers of clothing. In addition, as part of Review of the notes revealed these daily rounds, room inspections will be made on the PRTF to ensure that compliance is being met with the policy on 1) three changes of clothing per patient (one set on, two available to them) and not in excess of same and 2) observation for multiple layers of

Division of Health Service Regulation

Review of Health Incident Review Report for

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) clothing of patients. The findings of this review will V 115 Continued From page 46 V 115 be reported at the Morning Meeting of Hospital Resident #2 completed by RN #2 and dated Leadership Staff, Monday through Friday. These findings will be aggregated and presented on a 01/01/2018 recorded 1 weekly basis to the newly formed SBC, Charlotte PRTF PI Committee. A Governing Board member shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, recommendations, and actions taken will be forwarded by the Director of Quality/Compliance/ ." Review of Risk to the Hospital's monthly Quality/PI Council, the report revealed the date and time of the Medical Executive Committee and Governing Board elopement was 01/01/2018 at 2155. at each of their respective meetings Interview on 01/12/2018 at 1015 with RN #5 Root cause (contributing factor): revealed Resident #1 was admitted to the 7) Staff verbalized sometimes feeling "ill equipped" hall due to elopement risk. Interview revealed we to handle the number and acuity of patients (a) The criteria for admission has been revised to exclude patients with a history of felonious behavior, history of elopement from a facility, history of gang Interview revealed we involvement, history of substance abuse disorder, and history of a conflict or affiliate relationship with a current resident of SBC Charlotte. All staff are being inserviced on their ability to 7. Resident #1 said they had contact and utilize the police department if a patient Interview revealed from that point event escalates to one that cannot be otherwise forward Resident #1 and Resident #2 were not to handled by the staff on duty. In order to remain on be on the same hall together. the schedule, staff not in attendance for the inservice are required to receive training on this 3. Open medical record review of Resident #11 requirement prior to any scheduled work by the admitted to the revealed a completion date. PRTF on /2017 with The new CEO is now conducting rounds on each nursing unit. Evening and weekend shifts are being covered by the Administrator on Call. The questions Further review of the "Admission Intake that are standardly being asked include the following Assessment Form\* dated /2017 stated that are adapted from the Studer model: (1)Do you have the right tools that you need to do Resident #11 had the following risk and history of your job today effectively? If not, what is needed? violence: ' (2)Do you have the right amount of people to do Based on your job effectively? If not, describe. the medical record review there was no evidence available to determine facility staff implemented a

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treatment plan to address the history of elopement and patterns of violence. Review of

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL0601258 B. WING 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) (3)Is there anyone that you want to recognize today 2/16/18 V 115 V 115 Continued From page 47 as a team member that has been especially helpful Revised facility video recordings on 01/10/2018 of to you? If so, who? rounds (4) Are you feeling safe on your unit? If not, why? residential hallways on 01/1/2018, revealed (5) Is there any way that we can further support you? model in Resident #11, fully dressed in place Three evidence-based programs have been identified to assist staff in gaining more effective Review of admission orders revealed the resident skills in working with patients in the PRTF was placed on every 15 minutes observation and 3/31/18 environment. One is known as the Collaborative remained on every 15 minute observation on Problem Solving® (CPS) model. The tool has been New care 01/01/2018. Review of an Observation Sheet highly successful in reducing aggressive patient model dated 01/01/2018 revealed the resident was behaviors as well as eliminating the need for assigned to Room on 01/01/2018. Review restraint and seclusion in multiple acute hospital of an Observation Sheet dated 01/01/2018 settings (http://www.thinkkids.org/learn/ourrevealed every 15 minute checks were collaborative-problem-solving-approach/). The documented from 0000 through 2345. Review second tool is from Advanced Trauma Solutions revealed the resident was located at " (advanced trauma.com). The last tool is the CARE from program model that is supported by UNC Charlotte then from then and Duke. All programs utilize a trauma-informed l: then ' " from care approach but do not use a level system. from ; then from b) Date of completion: Implementation of new patient care model 03/31/2018 Review of Night shift notes recorded by MHT #17 Implementation of rounding using Studer Model revealed tool: 02/16/2018 c) Responsible person: Chief Executive Officer d)Monitoring procedure to ensure correction " Review of notes at 2202 revealed 7) Staff's perceptions about feeling "ill equipped" to handle the number and acuity of patients is being monitored as follows: As part of the daily rounds made by the CEO, staff will be asked to answer the following questions: (1) Do you have the right tools that you need to do your job today effectively? If not, what is needed? ." A nursing note by RN #1 on (2) Do you have the right amount of people to do 01/02/2018 at 0000 recorded " your job effectively? If not, describe. Nursing notes documented by RN #5 dated

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) (3) Is there anyone that you want to recognize today V 115 Continued From page 48 V 115 as a team member that has been especially helpful 01/02/2018 at 1330 recorded ' to you? If so, who? (4) Are you feeling safe on your unit? If not, why? (5) Is there any way that we can further support you? " Notes at 2200 recorded the resident was transported to a These rounds will occur daily (weekends covered by AOC). The findings of this review will be reported at for evaluation and returned from the Morning Meeting of Hospital Leadership Staff, 01/03/2018 at . Notes revealed the resident Monday through Friday. and These findings will be aggregated and presented on a . Notes revealed weekly basis to the newly formed SBC, Charlotte medication was administered. Review of an LPN PRTF PI Committee. A Governing Board member note dated 01/02/2018 at 0050 recorded shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, recommendations, and actions taken will be forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/Pi Council, Medical Executive Committee and Governing Board at each of their respective meetings. Review of the medical record on 01/10/2018 Root cause (contributing factor): revealed no further documentation of a nursing 8) Perception of staff of being "short staffed" on 1/5/18 assessment in the record after return from some shifts Staffing elopement on 01/01/2018. Review on 01/11/2018 analysis as revealed a nursing note documented by RN #5 a) The criteria for admission has been revised to dated 01/02/2018 at 0010 that recorded exclude patients with a history of felonious behavior, part of RCA history of elopement from a facility, history of gang review involvement, history of substance abuse disorder, and history of a conflict or affiliate relationship with a current resident of SBC Charlotte. 2/16/18 Studer The new CEO for SBC, Charlotte is now making rounds on each nursing unit. Evening and weekend rounds shifts are being covered by the Administrator on Call. model in One of the questions that is standardly being asked place includes the following that is adapted from the Studer model and that is specific to staffing: "Do you have the right amount of people to do your job effectively? If not, describe". Real time ." Review of a psychiatrist note recorded assessment of staff's perceptions and interventions, on 01/04/2018 at 1112 revealed "...

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	alth Service Regu	T				
STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0601258	B. WING	commonwealth of a substitution of the commonwealth of the commonwe	01/17/2018	
NAME OF PROVID	ER OR SUPPLIER	ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
STRATEGICBE	HAVIORALCENTE	R-CHARLOTTE 17	15 SHARON ROAD W	EST		
		CI	HARLOTTE, NC 2821	0		
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V 115 Cor	ntinued From pag	49	V 115	as appropriate to reduce their discomfort employed. Examples include calling in a PI member or reallocating staff to the area w is a perception of "short staffing".	RN staff	
: ••		" cord review of Resident #7	,	A daily review of staffing coverage for all s now being reported to the Hospital's Morr Meeting of Leadership staff. Shifts out of with staffing are addressed through PRN c leadership assisting with any deficits in sar	ning compliance overage or	
PR'	realed a TF on 72017	admitted to the with	:	Whenever there is a patient event requirir cause analysis, the adequacy of staffing an competencies and qualifications of staff at to determine if staffing might have been a the occurrence or prevention of same.	nd re assessed	
Ass	Assessment Form" dated 2017 stated Resident #7 had the following risk and history of			(b) Date of implementation of all elemen	its:	
revi det	iew there was no ermine facility sta	Based on the medical reco evidence available to ff implemented a treatment istory of elopement and		Rounds by CEO using Studer model: 02/1 Daily review of staffing coverage and inclustaffing as a part of RCA discussion: 01/05	usion of	
pat rec	terns of violence. ordings on 01/10/	Review of facility video 2018 of residential hallway ed Resident #7, fully dress		(c) Responsible person: Director of Nursing		
. in				(d)Monitoring procedure to ensure c	orrection	
was ren 01/ dat	s placed on every nained on every 1 01/2018. Review red 01/01/2018 re	orders revealed the reside 15 minutes observation ar 5 minute observation on of an Observation Sheet vealed the resident was	nd	8) Staff's perceptions about being short-st being monitored as follows: As part of the daily rounds made by the O will be asked to answer the following que "Do you have the right amount of people	CEO, staff stions:	
of a	an Observation Si realed every 15 m	on 01/01/2018. Reviewed the dated 01/01/2018 inute checks were 100 through 2345. Review	i	job effectively? If not, describe." These rounds will occur daily (evenings ar weekends covered by AOC).	·	
	realed the resider ; then ' ; then '		1	On a daily basis, the Director of Nursing is on compliance with staffing requirements nursing	. •	
	then "					

Division of Health Service Regulation

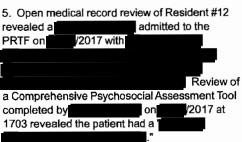
STATE FORM

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: B. WING 01/17/2018 MHL0601258 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES מו (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) units. The findings from these activities are being V 115 Continued From page 50 V 115 reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. then: t" from Review of ' from The findings of compliance with staffing grids and Night shift notes recorded by MHT #13 revealed staff's perceptions about staffing are being aggregated and presented on a weekly basis to the newly formed SBC, Charlotte PRTF PI Committee. A Governing Board member shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, recommendations, and actions taken are being ..." Review of nursing notes forwarded by the Director of Quality/Compliance/ documented by RN #1 dated 01/01/2018 at 2015 Risk to the Hospital's monthly Quality/PI Council, revealed the resident was Medical Executive Committee and Governing Board and offered and refused pm (as needed) at each of their respective meetings. In addition to . Review of notes at 2202 medication for the above, The findings from all Root Cause analyses revealed ' where staffing number is felt to have been a factor are being presented to the Governing Board at each of their respective meetings. Root cause (contributing factor): 9) Supplies and equipment not readily available to 1/15/18." A nursing note by RN #1 on staff. Specific reference is made to walkie talkies 01/02/2018 at 0000 recorded ' and batteries for same. (a) Walkie talkies were obtained whereby there is Review of nursing notes documented by an LPN now one available for all patient care staff including dated 01/02/2018 at 0130 recorded ' an intern who may work on that shift. Extra batteries for the walkie talkies were placed in the Milieu Manager's office. The office is accessible to ." Nursing noted staff. MHT staff are assigned with ensuring that the walkie talkies are all functional at the start of the shift for each respective work area. Nursing notes documented by RN #5 dated 01/02/2018 at 1300 recorded ) The new CEO is now conducting rounds on each nursing unit. Evening and weekend shifts are being covered by the Administrator on Call. The questions Notes at 2200 recorded the resident was that are standardly being asked include the following transported to that are adapted from the Studer model: "Do you have the right tools that you need to do your job for evaluation and today effectively? If not, what is needed? on 01/03/2018 at 0645. returned from

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Notes revealed the resident had

PRINTED: 02/07/2018 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY** (b) Date of completion: V 115 V 115 Continued From page 51 Purchase of walkie talkies and placement of batteries in medication rooms: 01/15/2018 Notes Implementation of rounding question: 02/16/2018 revealed was administered. Review of the medical record on (c) Responsible person: 01/10/2018 revealed no documentation of a Milieu Manager nursing assessment in the record. Review on 01/11/2018 revealed a nursing note documented (d) Monitoring procedure to ensure correction by RN #5 dated 01/02/2018 at 0010 that recorded 9) The use of the walkie talkies will be assessed as part of any Root Cause analysis to determine if the technological equipment present for use was properly utilized. AOC's will evaluate if staff have a walkie talkie on their person at all times that they are in patient care Record areas. review revealed the resident was discharged on /2018. Staff's perceptions on supply and equipment availability are being monitored as follows:



Further review of the medical record revealed there was no evidence available to determine facility staff implemented a treatment plan to address the history of elopement. Review of facility video recordings on 01/10/2018 of residential hallways on 01/1/2018, revealed Resident #12, fully dressed in

Review of admission orders revealed the resident was placed on every 15 minute observations and remained on every 15 minute observation on 01/01/2018. Review of an Observation Sheet

As part of the daily rounds made by the CEO, staff will be asked to answer the following question: "Do you have the tools that you need to do your job today effectively? If not, what is needed?" These rounds will occur daily (evenings and weekends covered by AOC). The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. The findings of evidence of walkie talkies available at time of an event triggering a root cause analysis and staff's feedback on the availability of supplies and equipment will be aggregated and presented on a weekly basis to the newly formed SBC, Charlotte PRTF PI Committee. A Governing Board member shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, recommendations, and actions taken will be forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and Governing Board at each of their respective meetings.

Division	of Health Service Regu	lation			-
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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				ADDROPRIATE REFICIENCY	2/20/40
V 115	Continued From page	∍ 52	V 115	Root cause (contributing factor):	2/28/18
	dated 01/01/2019 row	realed the resident was		10) Perception by staff that there has be	
		on 01/01/2018. Review of		change (at date of survey) to address inc	idents and
		t dated 01/01/2018 revealed		re-training on gears/de-escalation.  (a) Changes made to the SBC Charlotte en	virannant
	•	ks were documented from		will be compiled and posted in employee that staff are aware of same.	areas so
	was located at "	Review revealed the resident		that stan are aware or same.	
		; then " from		The CEO will conduct roundtables with sta	aff to learn
	from	; then " from hen "		more about their perceptions on changes	
				address incidents and re-training on geam	
	" from	; then "		escalation.	,,
	Davious of Night shift	notes recorded by MHT #16			
	revealed "	notes recorded by WiFT #16		An electronic safety survey has been depl	oved for
	revealed			use at the facility. Staff will have the ability	•
				complete the survey electronically or by h	•
				There will be no way to identify the staff	submitting
				the content to ensure that staff talk more	freely
				about any concerns. The findings from th	e survey
	" Paviou of the mo	dical record on 01/10/2018		will be used to improve on systems or pro	omotion of
	revealed no docume			same. The survey will be repeated in thre	e and six
	assessment in the re			months to review for evidence of progres	s made.
	assessment in the re	cord.			
	Interview on 01/12/20	018 at 0955 with RN #5		(b) Date of completion of all elements: (	02/28/2018
		nt had a daily observation		(c) Responsible person:	
		ssigned to the resident is		Human Resources Director	
		the 15 minute observation		numan nesources pirector	
	•	vealed the 15 minute checks		(d)Monitoring procedure to ensure corre	ection
	means "eyes on the	resident and they know		10) The results from the survey will be co	
	exactly where the res	sident is, document location		assess for evidence in improvement of re	•
	and initial." RN #5 st	ated that the residents that		findings of this	
		8 started coming back one at		will be aggregated and presented	
	a time around 0000.	The nurse stated it took		to the newly formed SBC, Charlotte PRTF	PI
		ites to get them all back. RN		Committee. A Governing Board member	shall be an
		tion sheets for Resident #12		attendee of that meeting to hear the resu	
		accurate. The nurse stated		actions. The findings, conclusions,	
	it was documented the	nat the resident was in the		recommendations, and actions taken pur	
		but didn't return until		the safety survey's results will be forward	•
		have laid eyes on the		Director of Quality/Compliance/ Risk to t	
		back yet. I don't know why		Hospital's monthly Quality/PI Council, Me	
	she documented tha	-		Executive Committee and Governing Boa	rd at each
				of their respective meetings.	

Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Root cause (contributing factor): 2/13/18 V 115 V 115 Continued From page 53 11) Administrator On Call (AOC) phone number not 6. Open medical review on 01/11/2018 of readily available to staff Resident #9 revealed a (a) The AOC on-call number is now posted with the admitted to the PRTF unit on /2017 due to nursing schedule in employee-only areas. Additionally, the schedule is posted with the Nursing staffing book. . Review of the (b) Date of completion: 02/13/2018 Intake Assessment dated 11/06/2017 revealed Resident #9 was at risk for elopement with a (c) Responsible person: history of " ." Review revealed **Human Resources Director** Resident #9 was not placed on elopement precautions on admission. (d) Monitoring procedure to ensure correction 11) As part of the daily rounds made by the CEO and Further review of the medical record revealed Leadership team, the staffing sheet will be assessed there was no evidence available to determine to ensure that it has the current name/contact facility staff implemented a treatment plan to number of the AOC. These rounds will occur daily address the history of elopement. Review of (evenings and weekends covered by AOC). The facility video recordings on 01/10/2018 of findings of this review will be reported at the residential hallways on 01/1/2018 revealed Morning Meeting of Hospital Leadership Staff, Resident #2, fully dressed in Monday through Friday. These findings will be aggregated and presented on a Review revealed Resident #9 lived on the weekly basis to the newly formed SBC, Charlotte hall. Review of a nursing note dated 01/01/2018 PRTF PI Committee. A Governing Board member at 2120 revealed Resident #9 " shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, recommendations, and actions taken will be forwarded by the Director of Quality/Compliance/ Review of an Observation Sheet dated Risk to the Hospital's monthly Quality/PI Council, 01/01/2018 revealed every 15 minute checks Medical Executive Committee and Governing Board were documented from 0000 through 2345. at each of their respective meetings. 2/2/18 Review of the Q 15 Minute Observation sheet Med room dated 01/01/2018 revealed Resident #9's location Root cause (contributing factor): was " 12) One nursing station was used for medication ." Review revealed a nursing passes of all units and, as a result, created a risk of note documented by RN #5 dated 01/02/2018 at inadvertently mixing patient groups. 2/18/18 0010 that recorded " Med audits (a) The use of the one medication room for medication dispensing was discontinued and staff prohibited from utilizing this system (see Attachment

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6 for medication administration clarification).

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 01/17/2018 MHL0601258 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE **CHARLOTTE, NC 28210** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Root cause (contributing factor): 1/ 17 /18 V 115 V 115 Continued From page 55 13)Process for accessing police was not clear to staff Meeting of the intake assessment revealed the resident with Police was currently (a) All Hospital staff are receiving training specific to . Further review of the intake assessment the expectation that the Charlotte Police Department is to be called if there is a patient 2/18/18 revealed documentation of elopement risk related situation that is unable to be managed by personnel | Completion on site. It has been further clarified that the on-site of training Supervisor or Charge Nurse is empowered to contact on policy the Police Department and does not have to have Further review of the "Admission Intake approval by any off site administrative staff to do so. Assessment Form" dated 12/22/2017 stated In order to remain on the schedule, staff not in Resident #10 had the following risk and history of attendance for the inservice are required to receive violence: ' training on this requirement prior to any scheduled " Based on work by the completion date. the medical record review there was no evidence available to determine facility staff implemented a A meeting was held with the Charlotte Police treatment plan to address the history of Department to discuss the appropriateness of elopement and patterns of violence. Review of contacting them and to ensure their agreement that facility video recordings on 01/10/2018 of in situations that cannot otherwise be handled by residential hallways on 01/1/2018 revealed staff and that may impact the safety of staff or Resident #10, fully dressed in residents that the police may be contacted for assistance. Review of the record revealed a nursing note documented by RN #1 dated 01/01/2018 at 2045 100% of key events including restrictive that recorded ' interventions, aggressive acts of patients to patients ." Review of the record and patients to staff, and reports of staff perceptions revealed a note documented by RN #1 dated of lack of adequate staff to handle a patient situation 01/01/2018 at 2202 that recorded ' will occur daily (Monday through Friday with the results of Friday, Saturday, and Sunday incorporated into Monday's report) will be reviewed to assess if the Police were contacted, when indicated and, if not, the reasons for same. Re-training and reclarification of the use and contact of the Charlotte Police Dept. will occur. Staff not meeting these requirements after re-training will be addressed on a ." Review of the record revealed a note progressive disciplinary basis. documented by RN #1 dated 01/02/2018 at 0000 that recorded ' (b) Date of Completion: Meeting with Charlotte Police Dept.: 01/17/2018 ." Review of an Observation Sheet Completion of training on policy: 02/18/2018 dated 01/01/2018 revealed the resident was (c) Responsible Person: Director on 01/01/2018. Review assigned to Room Quality/Compliance/Risk of the Observation Sheet dated 01/01/2018

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF ID PREFIX (X5) (X4) ID CORRECTION (EACH CORRECTIVE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENT (d) Monitoring procedure to ensure correction V 115 V 115 Continued From page 56 13) Compliance with staff contacting the Police, revealed every 15 minute checks were recorded as instructed per policy will be monitored as from 0000 through 2345. Review revealed the follows: resident was located at "5 1930, at A 100% review of key events including , at from restrictive interventions, aggressive acts of at from 2130 patients to patients and patients to staff, and through reports of staff perceptions of lack of adequate from Review of the staff to handle a patient situation will occur daily Observation Sheet dated 01/02/2018 revealed (Monday through Friday with the results of every 15 minute checks were recorded from 0000 Friday, Saturday, and Sunday incorporated into through 2345. Review revealed the resident was Monday's report) to assess if the Police were from located at " contacted, when indicated. The findings of this Review of the night shift notes recorded by MHT review will be reported at the Morning Meeting #16 revealed the resident " of Hospital Leadership Staff, Monday through These findings will be aggregated and presented on a weekly basis to the newly formed SBC, Charlotte " Review of the medical PRTF PI Committee. A Governing Board member record on 01/10/2018 revealed no documentation shall be an attendee of that meeting to hear the of a nursing assessment in the record. Review of results and actions. The findings, conclusions, the record on 01/11/2018 revealed a nursing note recommendations, and actions taken will be documented by RN #5 dated 01/02/2018 at 0010 forwarded by the Director of that recorded the resident returned to the facility Quality/Compliance/Risk to the Hospital's . Note recorded the resident was " monthly Quality/PI Council, Medical Executive " Note recorded that Committee and Governing Board at each of their were ' respective meetings. Root cause (contributing factor): 2/18/18 14) EOC issues not always being reported in a timely fashion. Specific reference is made to doors and furniture that, if not in optimal condition, could pose a safety hazard for ." Review of telephone orders dated residents/staff. 01/02/2018 not timed revealed orders to place Resident #10 on a) A memorandum is being prepared and h and distributed to all staff to alert them of the need upon return to facility. Review of a Case to communicate any identified doors or furniture Management Note documented by the Director of that could pose a safety hazard for Clinical Services (DCS), dated 01/02/2018 and residents/staff. signed as "Late Entry" on 01/03/2018 not timed

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revealed she met with the client, the Director of

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) b) Date of completion: 02/18/2018 V 115 V 115 Continued From page 57 Nursing (DON) and the Milieu Manager (MM) (c) Responsible person: Director of EOC after the resident was returned to the facility . Note recorded the DCS (d)Monitoring procedure to ensure correction and the DON questioned client about any injuries, 14) During the daily EOC rounds, the EOC Director pain or other concerns. Note recorded the DCS will assess for evidence of doors or furniture that, if set expectations for resident's return to the unit. compromised or malfunctioning, could pose a safety Note recorded the client was assessed by a hazard for residents/staff. The item will be taken out Registered Nurse (RN). Review of the of service or removed from the area, as appropriate. Psychiatrist progress note dated 01/04/2018 at The EOC Director will assess for evidence of 1249 revealed " notification of equipment/furniture potential safety issues. The summary of findings by the EOC Director will be reported at the Morning meeting of Hospital Leadership staff on a Monday through Friday basis. These findings will be aggregated and presented on a weekly basis to the newly formed SBC, Charlotte PRTF PI Committee. A Governing Board member shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, Review of a Health Incident Review Report for recommendations, and actions taken will be Resident #10 completed by RN #1 and dated forwarded by the Director of Quality/Compliance/ 01/01/2018 recorded " Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and Governing Board at each of their respective meetings. Root cause (contributing factor): 15) Doors being left open by staff at night were not 2/18/18." Review of the report revealed the date and secured between units, thus increasing risk of time of the elopement was 01/01/2018 at 2155. patients intermixing inappropriately. Open medical record review of Resident #8 a) A follow-up memorandum is being prepared and distributed to all staff to alert them that they are not revealed a admitted to the PRTF on I /2017 with to leave the doors open between units as this Review of a Comprehensive compromises the security of these units. Psychosocial Assessment Tool completed by b) Date of completion: 02/18/2018 2017 at 1000 revealed the patient stated, " c) Responsible person: Review of admission orders revealed the resident Director of EOC was placed on every 15 minutes observation and

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01/01/2018.

remained on every 15 minute observation on

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
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V 115	Room on 01/01 Observation Sheet day every 15 minute check 0000 through 2345. It was located at "from from then "then "from from the from t	ation Sheet dated the resident was assigned to /2018. Review of an ated 01/01/2018 revealed ks were documented from Review revealed the resident " at the " then " at ; then " then " at ; then " then " then " then " at ; then "	V 115	(d) Monitoring procedure to ensure corre 15)Compliance with keeping the unit door will be monitored by the AOC on a daily be through carnera means.  The summary of findings by the EOC Direct reported at the Morning meeting of Hospi Leadership staff on a Monday through Fric These findings will be aggregated and presweekly basis to the newly formed SBC, Chapart PI Committee. A Governing Board mishall be an attendee of that meeting to he results and actions. The findings, conclusion recommendations, and actions taken will forwarded by the Director of Quality/PI Committee and Governat each of their respective meetings.  Root cause (contributing factor):  16) S&R policy and procedure not consist followed per requirements)	s closed siss  tor will be tal lay basis. sented on a arlotte ember ar the ons, oe pliance/ iouncil, ing Board				
	dated 01/01/2018 at was involved in and Review of notes at 22 by RN #1 on 01/02/2	tes documented by RN #1 2030 revealed the resident 2022 revealed "  "" A nursing note 018 at 0000 recorded  "" Review of the medical B revealed no documentation ment in the record. Review		All nursing staff with responsibility for secrestraint requirements are being apprised inservice activity of the requirements specassociated policy and procedure. In orderemain on the schedule, staff not in attendine inservice are required to receive training requirement prior to any scheduled work completion date.  The policy and procedure for Seclusion and has been reviewed with the Medical Staff their compliance with the associated required to part of completion: 02/18/2018  c) Responsible person: Director of Quality/Compliance/Risk	through ific to the if to dance for ing on this by the  d Restraint to ensure				

PRINTED: 02/07/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE **CHARLOTTE, NC 28210** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (d) Monitoring procedure to ensure correction V 115 Continued From page 59 V 115 on 01/11/2018 revealed a nursing note 16) 100% of episodes of Seclusion and Restraint will be monitored for compliance with requirements in documented by RN #5 dated 01/02/2018 at 0010 accordance with the policy and procedure. that recorded The summary of findings by the Director of Quality/Compliance/Risk will be reported at the Morning meeting of Hospital Leadership staff on a Monday through Friday basis. ." Review of a These findings will be aggregated and presented on a psychiatrist note dated 01/06/2018 at 1054 weekly basis to the newly formed SBC, Charlotte revealed ' PRTF PI Committee. A Governing Board member shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, recommendations, and actions taken will be forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and Governing Board Review of a Health Incident Review Report for at each of their respective meetings. Resident #8 dated 01/01/2018 at 2155 revealed 9. Closed medical record review of Patient #3 on 01/09/2018 revealed a /2017 as a admitted to the PRTF or Review of the record revealed the admission diagnosis was Review of a nursing note dated 01/01/2018 timed at 1031 revealed a blank "Nursing Shift Note." Review of a restrictive

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and timed at 2145 revealed '

intervention on 01/01/2018 from 2002 to 2008 revealed Resident #3 was placed in a from 2002 to 2008 because

." Review of a nursing note (not dated)

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) V 115 V 115 Continued From page 61 10. Closed medical record review on 01/09/2018 of Resident #6 revealed a /2017 due to admitted to the PRTF on severe behavioral problems and violence. Resident #6 was /2018. Review of the ) or record revealed admission diagnoses included Review of the Q-15 Minute Observation Sheet dated 01/01/2018 revealed Resident #6 lived on I. Review of the Observation Sheet dated 01/01/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at ' fron ; and ' Review of the night shift notes recorded by MHT #16 revealed the resident was ' ". Review of the medical record on 01/09/2018 revealed no documentation of a nursing assessment in the record. Review on 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded the resident returned to the facility . Notes recorded the resident was ." Review of physician order dated 01/02/2018 revealed an order to place the

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notify the outside provider of clinical approval, get insurance approval, get document from referral

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-	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	T i	3) DATE SURVEY COMPLETED
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\/ 44E	Cantinuad From non	~ 62	V 115		
V 115	Continued From page	e 63	V 115		5 9 9 10 10
	provider and submit I	MCO-Insurance. I then			
	notify the provider, fa	cility or guardian and			
	schedule them to cor	ne in for admission. I send			
	the treatment plan, c	risis plan, data sheet and			
	referral to heads of e	ach department (head of			
	milieu, CEO, Educati	on, Therapy, DCS and DON)			
	a day in advance. N	o one comes in on			
	•	for weekend admission.			
		o admission or get signed on			
		n is present. Meet with			
	,	ission assessor) weekend			
	•	te intake assessment and			
		computer. Notify staff of			
		e MD and therapist see			
		urs." Interview revealed she			
	•	actors via email to the DON,			
	•	r department heads and			
	highlighting the risk f	actors within the email.			
	Interview on 01/12/2	018 at 1015 with RN #5			
		es the intake information via			
		at if she is not in the facility,			
		mation from the intake		•	
	, -	ext day. Interview revealed			
		received the information that			
		the medical record and			
		e for reading and reviewing			1
	the history and admi				
		018 at 1625 with AS #21			
		ent of residents on the 200			
	hall are decided bas				
		view revealed the boys and			
		eparate rooms, ideally splitting			
		s on one side and the girls on			
		nterview revealed gender,			
		nctioning plays a part in how			
	residents are assign	ed on the 200 hall.			
	Interview on 01/11/2	018 at 1726 with RN #5			
i	THE VIEW OF UT A 1/2	O TO at 11 20 Will NA #0			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	DISTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0601258	B. WING	****	01/17/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY, STATE	, ZIP CODE	
STRATEG	SIC BEHAVIORAL CENTE	R-CHARLOTTE 1715 SH	ARON ROAD WES	Г	
		CHARLO	OTTE, NC 28210		
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V 115	Continued From page	64	V 115		
	hall." We try to put all first 48 hours or so, d Interview revealed the hall and the boys go to bed available, we ma	ke 200 hall the "privileged new admits on 200 hall for ependent on their history. e girls typically go to the open hall. If there is no y admit to 200 hall. If they crying, we will place on 200			
	halls 01/01/2018 reversions and Hall 2133 MM #8 unlocker 200 hall from 300 hall (Testing Properties), Resident Hall to enter the 300	d the 300/200 door to enter			
	began throwing a tras tearing schedules off resident rooms. Other	sh can, tearing up paper, the wall, going in and out of er residents began to crowd			
	swung at MHT #1	nched MHT #10. Resident			
	staff were watching, a Resident , Reside followed MHT #10 do picked up MHT #10 f	and offered no assistance. ent and Resident when the hall. Resident worth the waist from behind			
	the residents and sta station locked door (o	ard onto his feet. He fell into  If standing at the 300 doc  Idoor exiting the unit). The  Idoo the other end of the hall.			
	2142 MM #8 walked 200/300 unit door. A Resident spit in M	back toward Resident #1 at s MM #8 was walking, HT #10's face. Resident #10's walkie talkie (in pieces)			
	and the residents we and stomping it.	re throwing it on the floor			

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2000 Resident and Resident

hallway over a piece of wall trim. MHT #11 picks up the trim and the walked toward the day room. 2001 Resident in hallway with another piece of wall trim and enters room 101. RN #1 and MHT #11 come down the hall with Resident

Resident hand the piece of wall trim to RN #1.

fighting in

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FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST

## STRATEGIC BEHAVIORAL CENTER-CHARLOTTE

CHARLOTTE, NC 28210

(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 115

## V 115 Continued From page 67

2045 Resident tearing the chair apart and getting wooden boards from chair. MHT #10 taking the board from Resident and gave to MHT #11 to lock in the bin room.

2046 Resident and MHT #10 go into room

2047 MHT #10 comes to room door and tosses a board toward the day room. Resident exits room 101 with a board. Resident using board to break thermostat. MHT #10 following. 2048 broken board thrown by Resident down hallway toward 100/200 door. MHT#12 picks up board and enters room 101, exits 101. Room 101 door remains open.

2053 MHT #12 exits 100 to 200 hall.

2057 MHT #12 and RN #1 enter 100 from 200 hall, enter room 101. RN #1 leaves 100 to 200 hall.

2058 RN #1 returns to 100 hall taking pictures with cell phone in room 101.

2059 RN #1 walks toward the day room. Resident goes into room 101.

2102 RN #1 returns to the 200 hall.

2106 Resident runs down hall and kicks 100/200 door and enters the 200 hall. MHT #10 follows.

2109 MM #8 enters 100 from 200 hall on cell phone.

2111 100/200 door opened. Resident comes from 200 to 100 hall, gets shoes.

2117 MM#8 exit the 100 hall to 200 hall.

2118 Resident enter room 101. MHT #10 at the door.

2119 MHT #10 turns room light on. Resident in bed in room 101. Resident run out of the room with two boards in his hand. MHT #10 follows.

2120 RN #2 and Resident #15 enter 100 from 200 hall.

2121 Resident exits room 101 toward

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 115 V 115 Continued From page 69 Resident ) and Resident ) go to Resident room 2020 Resident moved off hall. 200/100 hall door remains open. RN #2 and Resident returned to the 100 hall and the nurse left the hall. 2021 RN #2 in hallway. RN #1 in hallway taking pictures. 2022 RN #2 attempted to close 100/200 hall door Resident ) opened door 2023 Resident takes paper off the wall. Hallway is cluttered with paper on the floor toward the 200/300 end of the hallway. 2025 Resident and Resident ) come on the 200 hall and return to the 100 hall. 100/200 hall door remains open. 2129 Resident lunged through the door to the 200 hall. 2032 Resident returns to 100 ), Resident hall. Resident ) and Resident remain on 200 hall. Resident back to 200 hall. 2037 Resident ) to 200 hall 2203 RN #1 entered the 300 hall from the 200 hall. Resident entered the 300 hall through the door behind RN #1 from the 200 hall and walked directly into Room 306. Residen the final resident to elope from Room 306. Review of a Code Purple Log for 01/01/2018 revealed there were a total of seven Code Purple incidents called between 1659 and 2133 on the PRTF units. Review revealed a Code Purple was called on 01/01/2018 at 1659 on the 100 hall; 1706 in the cafeteria; 1708 on the 100 hall; 1918 location not documented; 2002 on the 300 hall; 2030 on the 300 hall; and 2133 on the 200 hall. Interview on 01/11/2018 from 1120-1245 with MHT #15 revealed she was working the 7pm-7am shift on 01/01/2018. Interview revealed

PRINTED: 02/07/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID PREFIX (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 115 Continued From page 70 V 115 she worked on the acute unit from October, 2016 to June, 2017 at which time she transferred to the PRTF unit. Interview revealed she did not go to shift change report. She went straight to the 300 hall. Interview revealed Name (MHT #28), who was assigned to 300 hall went to the classroom with residents to make phone calls. Interview revealed "I was on the 300 hall alone with female residents and male residents. Then 2 residents came back to the unit from phone calls. 2 residents had confrontation. Don't know if nurse on 200 hall. I had a walkie talkie. MHT (#28) returned to 300 hall and R.C. Name (MHT #34) returned to unit. Name (MHT #34) took Name (Resident ) off the unit to 300 dayroom. Resident became upset and went after the other resident ( ). Name (resident ) placed in hold by me. Name (MHT #34) back on the unit took Name (Resident ) to dayroom. Name (resident ) to her room. Name (MHT #17) and Name (MHT #13) came to unit. I went to rec room with 200 hall - Name (Resident ), Name (Resident ), and Name (Resident No one left on 200 hall. I believe Name (MHT #16) was on 200 hall. Name (Resident would go to 300 hall for bath, had words with Name (resident . Name (Resident everybody out to get him and Name (Resident ) possible altercation with Name (resident ) were on the ) sitting on the floor. Name 300 hall ( (MHT #15) and Name (MHT #14) were in the rec room. Name (resident ) started telling everyone

wanted to see Name (resident

(resident 8) fight. Name (resident 1) redirected. Asked Mr. Name (MHT #10) via walkie talkie (WT) if we could transition back up (a little after 8pm). Never checked to see if 100 hall finished meds. Ask Name (MHT #10) if he could meet us at the doc station (open area outside classroom 2 and 3 and 300 hall) he said

and Name

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room. Resident was in this room at the time.

Ask Resident to step out and close the door
(10 minutes). Mattress ripped open, crayons and

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MHL0601258 B. WING	01/17/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
1715 SHARON ROAD WEST	
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FILE IX	PROVIDER'S PLAN OF CORRECTION (X5) ACH CORRECTIVE ACTION SHOULD BE COMPLETE SS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
V 115 Continued From page 72 V 115	
books ripped, trying to tear Resident #16's clothes up. MHT #10 trying to get out of room. Resident the tried to rip electrical socket out of the wall, kicking the doors. MHT 15, MHT #14 and MHT #10 would get Resident off hall, then would come back. MM #8 would stop, redirect, the would go to 100 hall. Something on 300 hall would go over there. Name (RN #2) walking around trying to redirect. The only time I saw Ms. Name (RN #1) was when she stepped out on the hall to take pictures. Never said anything about placing in hold for safety. Neither gave direction. Resident threw water in the outlet. Metal plate in ceiling bent on 100 per Resident. At one point opened then closed. Ms. Name (RN #1) in the nurse's station. Ask why don't we call police to RN #1, she said "For what". Clearly we don't have control. RN #2 said she didn't know we could call the police. RN #2 prn nurse. RN #2 and MM #8 would walk all the halls - assessing the situation. No direction given from nurse, no better control. All boys on 300 hall, residents on 100 hall were asleep or playing games, 5 residents on 100 hall. Resident went over (from 200 to 300) after kids got out window. RN #2 went back to 300. I looked through the door. Resident bushed through, went though. Heard all the banging, the 200/300 door was closed."  Interview revealed the nurses are responsible for med passes, room checks, resident assessments for complaints such as sore throat, etc. MHT #15 stated "I feel Ms. Name (RN #1) is afraid of the residents. Name (RN #1) walked out 300/200 door and asked 'why didn't 'yall tell me the residents. Name (RN #1) walked out 300/200 door and asked 'why didn't 'yall tell me the residents got out'." Interview revealed she (MHT #15) lost her walkie talkie during the physical hold with Resident and of the shift. Interview revealed "Name	

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL0601258 B. WING 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 115 V 115 Continued From page 73 is supposed to respond to Gear 3 and Code Purple. She called so she could get males over to unit. MHT #11 and MHT #12 working on the 100 hall. Someone hit Name (MHT #12), he exited through 100 hall door to courtyard and reentered the unit through the 300/doc station door later. At this point Name (RN #4) came over, said it is not safe, we need to call the police. Mr. Name (MM #8) went outside." Interview revealed she had no involvement after residents returned to the facility until they were returned to the unit. Interview revealed she saw Resident and Resident Interview revealed the residents were still violent after elopement. Interview revealed "We had everybody (staff) arrive after elopement. No extra help prior to elopement. Name (RN #5) seen after police arrived." Interview revealed she was told the resident that eloped were returned to the doc station at 2245. MHT #15 revealed residents on elopement precautions should have their shoes removed from room, no outside privileges, and rooms searched per the facility policy. Interview revealed RN #5 wanted all shoes removed. Interview revealed the residents were not placed on one-on-one observation. Interview revealed "The kids said they hit the weakest team. Said Monday not planned, Friday had a plan - layers of clothes." Interview revealed she was not afraid but more "in awe" at the level of disrespect from the residents. Interview revealed she was not threatened by any resident. Interview revealed we should have assessed the situation and removed the resident(s) in danger. Interview revealed "Some staff are afraid of the kids and some are afraid of losing job because hold goes wrong."

STATE FORM

Interview revealed she attended a meeting with

Division	of Health Service Regu	ılation			
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V 115	Continued From page	e 74	V 115		
	AS #21 on 01/10/201	8 to discuss concerns with			
	"safety, kids, staff res	sponsibilities (who and when			
	a gear should be call	ed), ratio of staff to residents			
	2:6, competence issu	ies, equipped with walkie			
	talkies, what to do in	certain situations, what			
	should you say or do	, know when escalating,			
	watched a video and	what point to remove other			
	residents." Interview	revealed she felt like change			
	had occurred to an e	xtent, but some staff were			
	afraid to intervene wi	th residents. Interview			
		sed the number of staff			
	terminated because	of inappropriate holds.			!
		018 at 1645 with MHT #14			
		orking the 7pm-7am shift on			
		assigned to the 200 hall.			
		ne also worked the 7pm-7a m			
		and was assigned to the 200			
		ed she had been working on			
	the PRTF unit since	-			
		in the recreation room with			
		o eleven 200 half residents at			
		Interview revealed she and nly staff in the recreation			
		aled they left the recreation			
		and 2030 to transition the			
		and 2000 to transition the			
		e a walkie talkie. Interview			
		as called prior to bringing the			
		ack to the unit. Interview			
		#8 and Resident made			
		nna get that'. We knew			
		et someone but didn't know			
		aled "When we transitioned			
		Resident raced into room			
		ent . Came out of the			
		y fighting and MHT #17 and			
		m apart. Resident started			
		and Resident hit			
		face with a shoe, then			

PRINTED: 02/07/2018 FORM APPROVED

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Resident had taken stance in middle of hallway and pounced when door open and		•	_			
hallway and pounced when door open and						
MODODOG SAA HAID HALAH LAKAHINA 10 MAA HAID AA		• •	•			
much going on in the 100 and 300 hall, I told Ms.						

Division of Health Service Regulation

STATE FORM

Division (	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	IED
			Ì			
		MHL060125B	B. WING		01/17	7/2018
		WAILEGO 1200			1 01/1/	72010
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
CTD ATEC	ACDEMANADAL CENTE	1715 SH	IARON ROAD WEST			
SIRAIEG	IC BEHAVIORAL CENTE	R-CHARLOTTE CHARL	OTTE, NC 28210			
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PRRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION		COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
V 115	Continued From pag	e 76	V 115			
	Name (DN #4) also	and add to call the nation of				
	, ,	eeded to call the police or				
		. She was like where is the				
		. C. had someone in a hold. I				
	· ·	ame (RN #5). She (RN #1)				
		minutes later RN #4 from				
		nurse's station, RN #4 said				
		sense I am calling the police				
	_	s hurts'. One of the staff from				
		at window in room 306 had				
		idents had eloped. Staff				
		sident went through and				
	eloped out of broken	IHT #11 came to the 100/200				
		bobody here but myself, I need				
		okay I will call someone to				
		said he did not have a radio				
	so I gave him my wa					
	•	all nurses coming out to help				
	me. I would ask if I					
	INC. I WOULD ASK II I I	leeded fielp.				
	MHT #14 stated "Na	me (RN #1) came out to get				
		dent had taken out of the				
		#8 found the papers and				
		#1. She (RN #1) went back				
		ere she remained even after				
		was out of the nurse's				
		-escalate. RN #1 said 'why				
		et anyone know they had				
		dn't hear them call no code				
		ard one of the staff lost their				
		s. RN #1 hesitant due to				
	being kicked in the					
	Interview revealed o	n 01/01/2018 "I was afraid for				
		vealed she had received no				
	•	up since the 01/01/2018 and				
		lents. Interview revealed				
	"Gears" are called s	o the "nurse can come and				
		revealed the nurse gives the				
		it out of the manual hold.				

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	1	X3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		01/17/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
		1715 SH	ARON ROAD WES	Г	
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE CHARL	OTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
V 115	Continued From page	e 77	V 115		
	Intendeuroù e ete 4.0	a daara bahwaan (b -			
	Interview revealed the				
		d open to the magnet after			
		asleep. Interview revealed			
		off on the whole 100 hall.			f
		work on a different night			
		incident. I was on the hall			
	aione with 11 resider	ts when he left at 0000.			
	Interview on 01/17/20	018 from 1435-1450 with			
		alth Technician) revealed he			
	,	1-7am shift on 01/10/2018.			
	• .	e was in report at 1930 for			
		hift. Interview revealed			
		angry prior to my shift.			
		esident was very active.			
	He ripped out the bat				
	• • •	om 104. He broke a chair to			
		terview revealed "I went into			
	•	out, Name (MHT #10)			
		sident ) came out of			
	,	Someone mess with me I'm			
	going to you up' a	nd swung one time."			
	Interview revealed ar	nother resident walked into			
	room 104 and wante	d to use the broken objects			
	to hurt	riew revealed Resident			
		en tonight." Interview			
	revealed he told Res	ident at he was not here			
	to hurt and ask h				
		esident said "We passed			
		you up." Interview			
		12) tapped MHT #10 and said			
		. I walked to nurse Name			
		's station and asked to step			
		the 300 dayroom. I felt like I			
		t was chaotic. Ms. Name (RN			
		e situation." Interview			
		on the hall prior to the rkeys and to move patients			
		erview revealed MHT #17 and			

STATE FORM

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:	
	***************************************	MHL0601258	B. WING	Community of the Commun	01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	, ZIP CODE	
		1715 SH	ARON ROAD WEST	r	
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE CHARLO	OTTE, NC 28210		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(P.13)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	
IAG	NEGOE I, OKT OIT		IAG	DEFICIENCY)	TUTTE
V/ 115	Continued From page	78	V 115		,
• /	. 0		7 110		
		es off the 300 hall. Interview			
	•	inted to get hurt." Interview			
	revealed he met with	AS #23 face-to-face and			
	spoke with her by pho	one after the elopement.			
		)18 from 1215-1320 with			
		worked the 7p-7a shift on			
		w revealed a "Code Purple			
		as called between 1900 and			
	1930 during shift cha	•			
		HT #10 and MM #8 walked			
	upstairs, "destruction				
	•	st shift there." Interview			
		(mixed girls/boys) were			
		n room during the 100 hall g that occurs during change			
	•	2000 to better manage the			
	medication administr				
		e remained on the 200 hall			
	peeping through the				
		gave the "all clear" for the			
		back to the PRTF unit.			
		"vaguely remembered			
		giving medications" and			
		have said to me or by radio			
	, ,	or 200 hall, not exactly sure.			
		says she is ready for 200			
		Il clear." Interview revealed			
	"We have been short	staffed." Interview revealed			
	shift change report is	held in the downstairs break			
		0 and all 2nd shift staff			
	should be on their as	signed unit at 1930.			
	Interview revealed th	e day shift staff should not			
		lieved by night shift staff.			
	Interview revealed th	e staff should be together			
	during the transition	of residents. Interview			
		verbal/physical altercation			
		) when the 200 hall was			
	transitioned back to	200 from the Recreation			

Room. Interview revealed MM#8 was on the 300

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 115 V 115 Continued From page 79 hall managing/redirecting. Interview revealed when he arrived on the PRTF unit he immediately ). Interview checked on the 100 hall revealed Resident the 200 hall being "disruptive and impossible to redirect back to 100 hall. I don't think programming on 200 hall." Interview revealed he was redirecting on 200 hall when 200 hall transitioned from 300 hall and he heard a "big bang on the 100/200 door." Interview revealed when the 100/200 door was opened, he saw Resident had pushed a chair from the dayroom up the hall and rammed it into the door. Interview revealed "The kid is super strong." Interview revealed MHT #10 was asking "How Resident managed to get down the hall with the chair with no redirection." Interview revealed Resident "jumped through the 100/200 hall door and got onto the 200 hall. All my energy was directed to Name (resident). Name's (resident) room, tearing up the resident's clothing. Turned back to Name (resident), struck in head by Name (resident , prompted to leave room, staff removed Name (resident)." Interview revealed Resident and other residents tried to "tear (resident ) room and personal belongings, spiraled out of control." Interview revealed he had a walkie talkie at the beginning of the shift, but it was knocked off his clothes during one of the incidents. Interview revealed (resident was a kid. Because of strength, the only thing I could do was grab arm. I was not physically thinking about putting Name (resident) in a hold. Not successful calming down, stopped from hurting another person. was just damaging physical property. The gears were called at a certain point, but I can't remember everything about calling a gear." Interview revealed several staff on the hall to assist, but

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE **CHARLOTTE. NC 28210** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) V 115 Continued From page 80 V 115 doesn't recall MM #8 being present. Interview revealed he had received training on a 2-person hold during his Handle with Care training. Interview revealed the resident was moving around constantly and no one came to assist with restraining Name (Resident). He got on the 200 hall, remember Name (resident) talking to saying ----." Interview revealed he was eventually able to get resident back on the 100 hall and calmed down, even though was still destroying furniture. Interview revealed there were 2 male staff working on the 100 hall. Interview revealed resident threatened MHT #12 and he left the unit. Interview revealed he felt like he needed support to restrain the resident. Interview revealed the other residents should have been removed from the dayroom. Interview revealed the 100 hall could have been evacuated. Interview revealed "I never saw a nurse." Interview revealed the nurses had to know what was going on. Interview revealed one of the nurses (RN #1) walked onto the 100 hall/dayroom and took pictures while he was trying to de-escalate resident #1. Interview revealed the nurses make the decision to restrain a resident. Interview revealed RN#2 was on the hall intermittently. Interview revealed "No one tried to help me de-escalate Name (resident Interview revealed MM#8 took over re-directing of resident and removed him from the 300 hall. Interview revealed MM#8 left the 300 hall after "I was pushed by Name (resident ) and struck in the left ear by Name (resident ... Interview revealed there were several other staff members on the 300 hall. Interview revealed he pulled the Styrofoam cup off the camera bubble. Interview revealed he was struck in the face by a resident

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and was picked up by another resident and slammed down on his feet but was not hurt.

PRINTED: 02/07/2018

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 115 V 115 Continued From page 81 Interview revealed "Name (resident ) spit in my face. I went to the manager's office to calm myself down, then I went to the Milleu Manager's office. Interview revealed MM #8 and RN #4 were in the doc station (located outside the 300 hall door). Interview revealed MM #8 asked "Are you out?" Interview revealed he went downstairs, clocked out and left out of the building. Interview revealed he went to his car and sat for a little while and he did see the police officers when they arrived between 2200 and 2230. Interview revealed he was placed on light duty from 01/05/2018 through 01/09/2018 and only saw the 01/05/2018 incident from a distance. Interview revealed "We have been short staffed for 2 months. Not enough staff to be effective and supply the needs of the residents." Interview revealed he believed some changes could be made with the shift report/change of shift, number of staff available to transition residents and staff not waiting till 1930 to report to the unit/hall. Interview revealed "There is a potential that the same situation could happen again." Interview revealed "I am here to protect residents and staff." Interview revealed "Staff fear they will be reprimanded if they restrain a resident." Interview on 01/11/2018 from 1315-1430 with MHT #16 revealed she was working the 7pm-7am shift on 01/012018 and was assigned on the 300 hall. Interview revealed she was also assigned to float. Interview revealed Resident was pacing on the 300 hall when the altercation residents started. Interview between the revealed the altercation on the 300 hall began in room 305 and ended up in the hallway. Interview revealed MHT #10 was with Resident on the 200 hall at the nurse's station.

Interview revealed the medication passes were

PRINTED: 02/07/2018 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) V 115 Continued From page 82 V 115 not completed "boys didn't get meds". Interview revealed a "Code Purple" was called on the 300 hall around 2000. Interview revealed she was not sure if she heard the "Code Purple" called on the radio or through the 300/doc station door. Interview revealed there were few walkie talkies on the unit and no batteries to replace in the walkie talkie that were available, when they died. MHT #16 stated "I feel if Name (Resident been placed in a hold earlier this would have never got this bad. Residents should have been

assist. Interview revealed "Name (RN #1) claims she didn't know this was going on and doesn't respond." Interview revealed "I was at the far end of the hall (opposite of room 306), Resident came out of room 306 holding a board with nails. Resident was rolling up towels. Resident pushed and spit on MHT #10. Resident picked MHT #10 up and he put him down, did not hit the floor."

moved during this." Interview revealed RN #2 was on the hall helping de-escalate the residents. Interview revealed there was a "fear of residents". Interview revealed two nurses from the Acute Unit (RN #3 and RN #4) came over to the 300 hall to

Interview on 01/11/2018 from 1315-1430 with MHT #17 revealed she was working the 7pm-7am shift on 01/01/2018 and assigned on the 300 hall. Interview revealed she was "intimidated as far as safety." Interview revealed she nor the other staff on the 300 hall tried to open the door to room 306 after the residents barricaded themselves in the room. Interview revealed she pulled some of the female residents off the hall and into the 300 dayroom. Interview revealed the staff were all "shocked" and did not consider closing the door to room 306 after the first residents eloped. There was enough time to close and lock the door prior to the last resident

Division of Health Service Regulation STATE FORM

PRINTED: 02/07/2018 FORM APPROVED

	of Health Service Regu	·			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DINSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN O	FOURTECTION	DENTIFICATION NOMBER.	A. BUILDING:	entre programme de la companya de l Companya de la companya de la compa	COM LETED
		MHL0601258	B. WING		01/17/2018
NAME OF PE	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE	
TRANE OF T	TO VIDEN ON OUT PER		IARON ROAD WEST		
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	OTTE, NC 28210		
		The state of the s			
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	(X5) SE COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI	
				DEFICIENCY)	
V 115	Continued From page	e 83	V 115		
	, -				
		evealed MHT #10 left the 300			
	·	on and never returned to the			
	unit. MHT #10 went h	nome.			
	Interview revealed th	ere had been no change in			
		since the incidents and			
	•	de-escalation. Interview			
	• •	strative staff met with them			
		ginning of their 7pm-7am			i
		o review concerns. Interview			
		information needed to be			
	•	view revealed the PRTF unit			
		cause nothing had changed.			
	Interview revealed so	ome identified safety issues			
	include the "new me	dication pass process, doors			
	between residents' h	all being held or propped			
	open and activity cor	ming in."			
	MUT #12 was contac	cted on 01/17/2018 at 1017			
		s not available for interview.			
	and indicated no was	STOCK CONTROL OF THE POWE			
	Interview on 01/16/2	018 at 1640 with MM #8			
	revealed he was wor	rking during the incident on			
		aff member stated "It lasted a			
	long time. The 100 l	hall residents were on the			
	200 hall. All three ha	alls were in disarray. All the			
	residents were in the	e hallways, ignoring all			
		w revealed there were two			
		at worked called the pink			
		eam. Interview revealed the			
		ing on 01/01/2018. MM #8			
	•	k team is stronger because			
		est several staff over the past			
		ted there had been at least			
		the past two months, so the			
		ully staffed. MM #8 stated			
		e staff by numbers, but the ne staff was inadequate."			
		here was a Code Purple			
		all at shift change, around			

	of nearingervice Regu	<del>                                     </del>			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	3) DATE SURVEY COMPLETED
ANDFLANC	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:	Confidence accompany to a graphic at the confidence of the confide	COM ELTED
		MHL0601258	B. WING		01/17/2018
NAME OF D	DOVIDED OD SLIPBLIED	PTDEET A	DDRESS, CITY, STATE	ZIP CODE	
NAME OF PI	ROVIDER OR SUPPLIER				
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	ARON ROAD WES	T	
		CHARLO	OTTE, NC 28210		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETE DATE
170		,	,,,,,	DEFICIENCY)	
V/ 44E	O	- 04	V 445		1
V 115	Continued From page	8 64	V 115		4
	1930. MM #8 stated	"Staff opening the door was			
	stupid. They got from	n 200 to 300. 100 residents			
	got to 200 hall and th	ey were excessively			
	non-compliant and at	the same time there was an			
	incident going on the	300 hall. (Resident ) was			
	banging something a	gainst the door. Later I saw			
	it was broken boards	." MM #8 stated he had			
	gone outside when th	ne residents eloped and one			} .
	of the residents said	"Lets rush." Interview			
	-	reatening to rush MM #8			1
	•	ar and tried to keep visual			
	-	sidents, but lost them. MM			
	•	call the police. He stated he			
	_	tation and asked RN #1 for			
	•	on Call) and was told by RN			
		e that information, and that			
	-	e with RN #5. MM #8 stated			
		1, the receptionist called 911			
		11 around 2150. MM #8			
	_	nstantly calling Code Purples			
	•	got a response. (RN #1)			
		ard a Code Purple." Interview			
		sent RN #5 pictures of the			
		terview revealed the nurses			
	_	e milieu as a general rule.			
		e night, she (RN #1) was in			
	the nursing station."				
	Interview on 01/16/2	018 at 1725 with RN #2 (date			
		evealed she worked 7pm -			
	•	01/2018 and was present			
		t incident. Interview revealed			
	•	eeded, usually one to two			
		riew revealed the nurse was			9
		ould call the police when the			
		n 01/01/2018. The nurse			
		ved for work, the milieu was			
		nts were hyper and things got			
		. RN #2 stated "We lost			
		y out of control. They			

Division o	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	The first open state and the first open state of the stat	COMPLETED
		MHL0601258	B. WING		01/17/2018
NAME OF D	ROVIDER OR SUPPLIER	CTDEET A	DDRESS, CITY, STATE,	ZIRCODE	
NAME OF F	ROVIDER OR SUFFLIER				
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	ARON ROAD WEST		
			OTTE, NC 28210		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	(X5) E COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	
				DEFICIENCY)	
V 115	Continued From page	e 85	V 115		
	•	following directions. I was in			
	the hallway when (Re				
		rough each unit, 100, 200,			
		ould have had a three			
		determine what to do			
		at of control. I was not the			
		d (RN #1) over and over			
	_	don't know if she notified the			
		re fighting. Resident was			
	•	power more than anyone			
	_	of the unit. The kids had			
		e boys came through to 200			
		I never saw Resident			
		old about it and told was			
		d not see (RN #1) on the unit			
	that night. I had a wa	alkie (talkie). I am not sure if			
	she (RN #1) had a w	alkie (talkie)." Interview			
	revealed there is a w	alkie talkie in the nursing			
	station and it is alway	ys on. Interview revealed RN			
	,	ea came over to assist and			
		she could call the police.			
		re were no Code Purple			
	incidents called on 0				
		es are announced overhead			
		kies. Interview revealed the			
		e heard in the nursing			
	station and both nurs	ses would respond.			
	Intoniou on 04/44/0	018 from 0955-1035 with RN			
		9/2016) revealed she started			
		urse 2 years ago and took a			
	•	ition 1 year and 4 months			
		aled she was the nurse in			
		unit on 01/01/2018. Interview			
	revealed she arrived				
	Interview revealed m				
		not recall on which hall.			
		The residents are out of sort			
	at shift change." Into	erview revealed she spoke			

Division	of Health Service Regu	llauon			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED	
		MIII 0004070	B. WING		04/47/0040
		MHL0601258			01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE	
		1715 SH	ARON ROAD WEST	T	
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	OTTE, NC 28210		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE DATE
				DEI IOIEIO?)	William
V 115	Continued From page	e 86	V 115		
	with RN #5 (DON) ab	out the residents' behavior			
	, ,	erview revealed medications			
	•	00 and we usually start the			
		and 1900. Interview revealed			
		re acting up so I texted			
		re help. I told her we needed			
	, ,	el the amount of staff we had			
		calate what was going on.			
	•	bout the R.C. (resident			
	, ,	MM #8) informed about MHT			
		i call Name (RN #5) about			
	1	revealed "I was in and out a			
	1	alation. I called Name (RN			
	1	r and asked her to call the			
		on-call), as I didn't know who			
		Il specific incident, but felt			
		ing up. I was out on the floor			
	and in the nurse's sta	• .			
	and in the nuises st	auon.			
	Interview revealed th	ne R.C. on the hall is typically			
		y want to start the medication			
		00 hall (mixed boys/girls) are			
		e recreation room. Interview			
		remember if they were			
		8 and she did not recall if any			
	residents were on th	e 200 hall during the			
	medication pass. Into	erview revealed around 2200			
		red a call from Name (RN #3)			
		ere breaking out the window.			
		had no call to tell me. I			
	asked why they didn	't radio." Interview revealed			
	there were lots of thi	ngs going on in the unit.			
	Interview revealed th				
		gan looking for the residents.			
		was completing incident			
		perwork." Interview revealed			
		eturned approximately 2			
		lice department. The			
		ssed by Name (RN #5) and			
		lame (LPN #6). Interview			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	
		1715 SH	ARON ROAD WEST	г	
SIRAIEG	IC BEHAVIORAL CENTE	CHARLOTTE CHARLO	OTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE E DATE
V 115	Continued From page	e 87	V 115		
	revealed the resident	ts were placed in paper			
		om elopement. Interview			
	revealed there are m	onitors in the nursing station			
		to see what is going on in			
	each hall. Interview	revealed "I can't watch the			
	monitors all the time.	I have other things to do. It			
	would be nice to have				
		revealed she charted once a			
	shift around 2330.				
	Interview revealed de	e-escalation techniques were			
	ineffective on 01/01/2	2018. Interview revealed			
	"Each room has a tal	ole. Name (Resident )			
	broke a table on the	100 hall, tore outlet out, tore			
	•	wn in the hallway and pulled			
	the trim off around th				
	•	r was notified after the			
	•	v revealed "I did not call the			
	•	ons." Interview revealed			
		used to give standing orders.			
		nts call for each resident.			
		needed to be in a hold. on. Not enough staff. Two			
		n't recall census or staffing on			
	,	view revealed the staff had a			
		the residents on their			
	appropriate hall.				
	Interview revealed th	ne medication process			
		ring one patient at a time.			
		r. Radio to MHT on 100,			
	•	ds patients one at a time. Try			
		power the MHT and get			
		s happened before. Staff on			
		ith trying to get them back.			
		01/01/2018. I went out here			
		tion door and talked with the			Anna Carlos
		I don't recall what I did			1
	afterwards, I don't re	member if I called			

maintenance. We call directly. I did not see Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 115 Continued From page 88 V 115 maintenance prior to end of shift." Interview revealed "Lot involved don't recall. Don't recall hall where Name (Residen ) was located." Interview revealed she was not sure if more staff were brought in on 01/01/2018. She stated "Both nurses are responsible. All happened at one time. We were all afraid. We have the authority to call police. We lost total control at that point. No plan to regain control." RN #1 stated "I feel like I did all I could as the nurse in charge to get help. I talked with Name (RN #5-DON) and she said I did all I could do. We try to help the staff de-escalate the patients as much as possible. Went out earlier to help deescalate. Sure I went everywhere." Interview on 01/10/2018 at 1600 with RN #5 (date of hire 12/28/2016) revealed she was first notified by RN #1 on 01/01/2018 at 2117 that she was sending pictures of property damage done by Resident #1. RN #5 stated the pictures looked bad and she tried to call MM #8 and couldn't get an answer. The nurse stated she received a text from MM #8 at 2144 that stated "Need you in." RN #5 stated she tried to call the PRTF phone and didn't get an answer. Interview revealed RN #4 (acute care nurse) called her on her cell phone and said that they needed to call the police. RN #5 stated she told RN #4 to give her 15 seconds and let her call AS #21 (Interim CEO). She stated she called AS #21 and called RN #4 right back. RN #5 stated there was no record of the time the phone call from RN #4 was received. Interview revealed RN #5 arrived at the facility around the time the police arrived. She was unable to recall if the police were already there when she arrived.

Division of Health Service Regulation

Interview on 01/10/2018 at 1730 with RN #5 revealed when the residents were returned to the facility by the police after they eloped, they were

FORM APPROVED Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 115 Continued From page 89 V 115 seen by medics. Interview revealed they were brought in one at a time to the facility and assessed by herself and a therapist. Interview revealed there was no nursing documentation of a physical assessment of the residents upon return after elopement. Interview on 01/11/2018 at 1620 with AS #33 (administrative staff) revealed he was on call for EOC (environment of care) on 01/01/2018. Interview revealed he received a text message on his cell phone from AS #23 on 01/01/2018 at 2208 stating "need you at facility emergency." Interview revealed he spoke with RN #5 on the telephone at 2209 and she stated "kids kicked through window and eloped." Interview revealed RN #5 sent pictures to him via cell phone. Interview revealed he spoke with MM #9 at 2209 related to the same issues. Interview revealed he arrived to the facility around 2240. Interview revealed room 306 was closed and locked when he arrived. Interview revealed he went to the 300 hall, room 306 to observe the room and the window damage. Interview revealed he boarded up the window with plywood and changed the door lock to a lock that could only be unlocked by administrative staff, EOC staff or key that was locked in the Pyxis machine located in the PRTF nurse's station. Interview revealed he removed the broken boards, plexi-glass and paper from the unit and also removed the front piece of the broken thermostat, pushed wires back into the wall and covered with a cover until it could be repaired. Interview revealed there were no thermostat guard cover on the thermostats in the 100 hall dayroom. Interview revealed he covered the broken electrical outlets with a metal cover,

Division of Health Service Regulation

cut the breaker to 3 outlets in the 200 hallway and 100 hallway. Interview revealed all broken furniture (desks from 100 hall and chair from

Division of	of Health Service Regu	ılation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:	STRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		04/47/0048
		MHL0601258			01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE, ZI	P CODE	
CTDATEC	IC BEHAVIORAL CENTE	TRICHARI OTTE 1715 SH	ARON ROAD WEST		
SIRAIEG	IC BEHAVIORAL CENTE	CHARLO	TTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 115	Continued From page	e 90	V 115		
	dayroom) was remov	ed and carried outside the			
	building. Interview re	vealed he took the "planks"			
	_	ed from the chair and put			
	"security screws in th	e slats." Interview revealed			
	the double door betw	een the 100 and 200 halls			
	were not latching pro	perly from where it had been			
	kicked. He shaved to	p to get latch to work			
	properly. He tighten	ed the screws down in the			
		00 hall and 300 hall to "allow			
	for easier opening."				
		lass in room 106 (Resident			
		laced with a new piece" on			
	,	w revealed he was not			
		00 hall door not closing			
		the elopement/window			
	damage.				
	Telephone interview	on 01/09/2018 at 1015 with			
		as notified by MHT #10 on			
		/2018 that the PRTF was			
	"falling apart and no				
		nurse stated MHT #10 had			
	come to the eye was	h station because a resident			
	had spit in his eye. F	RN #3 reported that he and			
		one to the PRTF 300 hall and			
		uddled at the end of the hall			
		on." The nurse stated he			
		nd cussing, saw trash and			
	-	floor in the hallway. He			
		barricaded themselves in a			
		ad weapons made from the			
		escribed as "boards with six pard." The nurse stated			
		ying to get into the room and aff "They have weapons.			
		rse described the situation as			
		akdown." RN #3 stated MM			
		residents were kicking out a			
		se stated he went to the front			
		ng and saw the resident			

PRINTED: 02/07/2018 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 01/17/2018 MHL0601258 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 115 V 115 Continued From page 91 breaking out the window. He stated he told the receptionist to call 911 and was told "We can't call the police without permission." The nurse stated the kids were coming out the window with weapons "charging toward me with wood boards with screws. Ten children ran out. I returned to the hall. I had not seen RN #1 on the unit. She was assigned to PRTF (full time regular nurse). She said she was not notified of the incident, said not paged." Interview revealed twelve police officers and some administrative staff came. RN #3 reported he returned to his assigned unit. The nurse stated "It was a complete breakdown of everything." RN #3 stated it (incident on 01/01/2018) started on the 100 hall. He stated the doors were propped open. Telephone interview on 01/23/2018 at 1530 with RN #3 revealed "It has been a routine to leave the doors propped open on second shift evening and nights. Staffing is the primary reason. There is not enough. The boys are allowed to go onto the girls unit when the doors are open." RN #3 also stated that around six or more boys would come through the doors when staff would go through. The nurse stated there was "commingling for some time. It was common practice, every night, definitely the standard to leave the doors open. There was not enough staff to staff the units. Staff are afraid." Telephone interview on 01/14/2018 at 2316 with

Division of Health Service Regulation

RN #4 revealed she was working the 7pm-7am shift on the acute unit on 01/01/2018. Interview revealed she was working on the medication administration records when MHT #10 came in around 2145-2150 stating 'a resident had spit in his eye approximately 10 times'. He needed to use the eye wash station. MHT #10 stated 'The PRTF halls were completely out of control'.

Division of Health Service Regulation									
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:	ISTRUCTION	(X3) DATE SURVEY COMPLETED				
		MHL0601258	B. WING		01/17/2018				
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
220 475 6	1715 SHARON ROAD WEST								
STRAILG	STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE				
V 115	Continued From page	92	V 115						
	Interview revealed sh	e thought to herself, it can't							
		revealed she walked over							
	to the 300 hall and fo	und the unit was indeed out							
	of control and resider	nts were barricaded in room							
	_	vindow, trying to break it and							
	•	Interview revealed she told							
		while she went to the PRTF							
	•	ak with the nurse and find							
		n. Interview revealed she urse's station texting the							
		aled RN #1 did not come out							
		he was on the unit. RN #4							
		ımbered the staff." Interview							
	revealed the other nu	rse on the acute unit (RN							
	#3) had walked to the	e front door and saw MM #8							
	•	e 306 window trying to keep							
		uilding. Interview revealed							
ĺ		esidents overpowered MM							
	#3 told RN #4 that the	e to keep them inside." RN							
		, so he stepped back inside							
		ed the receptionist to call the							
	police due to residen	•							
	Interview revealed #	ere were 2 "Code Purple"							
		pement around 2000 and							
	•	nterview revealed the "Blue							
	•	on as well as the "Pink							
		ealed she worked with both							
	teams. Interview reve	ealed she will work on the							
	hall as a MHT if they	are short staffed. Interview							
	revealed the R.C.'s a	are assigned a hall on the							
	-	ut they typically roam and							
	assist as needed. Int	erview revealed there have							

been some changes in the environment since the 01/01/2018 and 01/05/2018 incidents. Interview revealed the DON arrived on 01/01/2018 around 2215. Interview revealed the current census (01/19/2018 at 2316) on 100 hall was 9 residents and 3 MHT's; 200 hall 11 residents and 3 MHT's;

DIVISION	of Health Service Regu	llation							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED				
			and the second s						
			D 14/19/2						
		MHL0601258	B. WING	A / A / A	01/17/2018				
NAME OF D	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STATI	E ZIP CODE					
INAME OF P	NO FIDER ON SUFFLIER								
STRATEG	STRATEGIC BEHAVIORAL CENTER-CHARLOTTE 1715 SHARON ROAD WEST								
		CHARLO	TTE, NC 28210						
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION					
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD					
TAG	REGULATORY ORT	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP! DEFICIENCY)	MAIE				
V 115	Continued From page	e 93	V 115						
1	200 hall 0 maidants	with 2 MUTo: 1 DN and 1							
		with 3 MHT's; 1 RN and 1							
	LPN on the PRTF un	it.							
	Intonious case de die-	enigement of admissions are							
		ssignment of admissions are							
		by the nurse on day shift							
		iew revealed residents with							
		tics are admitted to the 200							
		led recently, "All admissions							
1		ilable." Interview revealed							
	-	t shift are made when she							
		Interview revealed all room							
		approved by the previous							
	•	she can make room changes							
		eadership the next day as to							
		room change." Interview							
		and mental health techs work							
	together to make dec								
	"residents will manip	ulate room changes."							
	lata dama a 04/47/0	040 -4 0045 EN #4							
		018 at 0945 with RN #4							
		incidents over the weekend							
	•	physical holds and staffing							
	•	revealed the "night shift							
	report from other nur								
	assessors. May not								
		sident should not have							
	•	ame facility. Hx: knew each							
	-	roup home. Didn't know							
		1 week after residents							
		the assessors' sheets are not share drive." Interview							
		stration on call schedule is							
		ffice and brought to the unit bulletin board. Interview							
	•								
	revealed she sends	(AOC), DON and physician							
	•	y problems, issues or							
	concerns.								
	Inter-device - 04/47/0	0040 -4 4440 #b 40 #0.4							
1	interview on 01/17/2	2018 at 1110 with AS #24							

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE **CHARLOTTE, NC 28210** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 115 V 115 Continued From page 94 revealed Director of Nursing, Milieu Manager and Mental Health Technicians were available when the residents were returned to the facility by the police department after elopement. Interview revealed the residents were returned to the facility around midnight. Interview revealed we assessed and talked with the residents and then had a Mental Health Technician return the resident to the unit. Interview revealed the residents were brought into the acute unit waiting room and were brought back one-by-one to the intake room. Interview revealed on the morning of 01/02/2018, RN #1, MHT #16, MHT #12, MM #8, and AS #24 were present in the acute waiting room. In summary, facility staff failed to communicate resident's patterns of elopement for seven of ten residents and history of violent behaviors for ten of ten residents to care staff, failed to implement policies and elopement precautions thereby creating an unsafe environment for the delivery of safe resident care. As a result, residents destroyed wooden furniture and made weapons which placed residents and staff in an unsafe environment. Subsequently, ten residents eloped from the facility. B. 1. Open medical record review on 01/09/2018 for Resident #1 revealed a admitted to the Psychiatric Residential Treatment 2017 with diagnoses of Facility (PRTF) on Review of the intake assessment revealed the resident Further review of the intake assessment revealed documentation of homicidal risk and elopement risk related to the resident review revealed Resident #1 had a known history

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of elopement on admission and eloped from the

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 115 Continued From page 95 V 115 facility on 01/01/2018. Admission vital signs were the Psychiatrist Evaluation documented on /2017 at 2050 revealed ".. ..." Review of the medical record revealed documentation of a Resident #1 on 01/02/2017 from 1321-1342 for Review of the Medication Administration Record revealed documentation of administered on 01/05/2018 no time. Review of the Restrictive Intervention documentation dated 01/05/2018 at 2015 revealed a physician order for for Resident #1 was and . Resident #1 was . Restrictive intervention documentation revealed Resident #1 was on 01/05/2018 at 2015 and at 2040. Restrictive Intervention documentation revealed Resident #1 was at 2025. Review of the medical record revealed a nursing note documented by RN #5 on 01/05/2018 at 2040

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that recorded

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Division of Health Service Reg	ulation									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:	NSTRUCTION	(X3) DATE S COMPL						
	MHL0601258	B. WING		01/	17/2018					
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, 2	ZIP CODE							
STRATEGIC BEHAVIORAL CENT	STRATEGIC BEHAVIORAL CENTER-CHARLOTTE  1715 SHARON ROAD WEST CHARLOTTE, NC 28210									
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE					
V 115 Continued From page	ge 96	V 115								
revealed documenta Resident #1 on 01/0 Review of a nursing at 2130 revealed  ." Resident #1 was 01/05/2018 at 2224  Resident #1 was revealed Resident #	note documented by RN #5  view of nursing note #5 revealed  " Review of on documentation revealed on after  " Documentation									
	dated 01/05/2018 revealed the									

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STATE FORM

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 115 V 115 Continued From page 97 01/05/2018. Review of the Observation Sheet dated 01/05/2018 revealed every 15 minute checks were recorded from 0000 through 2030 and 2245 through 2345. Review of observation sheet revealed no available documentation of Resident #1's location on 01/05/2018 from 2045 through 2230. Review revealed the resident was located at " Review of the night shift notes dated 01/05/2018 recorded by MHT #11 revealed ' ." Review of physician orders revealed a telephone order dated 01/05/2018 at 2224 for . Review of orders revealed a telephone order dated 01/05/2018 not timed ' " Review of the medical record revealed documentation of Resident #1 on 01/05/2018 from 2224-2323 for Review of orders revealed a telephone order dated 01/06/2018 at 2224 " ." Review of the medical record revealed no available documentation of an observation sheet on 01/06/2018. Review of physician orders revealed a telephone order dated 01/07/2018 at 2224

Division o	of Health Service Regu	ılation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONS		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	opportunities of the control of the		
		MHL0601258	B. WING		01/17/2018	
NAME OF PE	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE, ZI	PCODE		
STRATEC	IC DELIANTODAL CENTE	D.CHARLOTTE 1715 SHA	ARON ROAD WEST			
SIRAIEG	IC BEHAVIORAL CENTE	CHARLOTTE	TTE, NC 28210			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
V 115	Continued From pag	e 98	V 115			
		و حصول مص				
		."				
	Review of the Obser					
		every 15 minute checks 2000 through 2345. Review				
		evealed a telephone order				
	dated 01/08/2018 at 1335					
		."				
	Review of the Observation Sheet dated 01/08/2018 revealed every 15 minute checks					
	were recorded from					
		ncident Review Report				
	· <u> </u>	and dated 01/05/2018				
	recorded '					
	-					
	Review of the report	revealed the date and time				
	of the incident was 0					
	:					
		ncident Review Report				
	recorded "	and dated 01/05/2018				
	Tecorded	_				
		1				
		view of the report revealed the incident was 01/05/2018 at				
	2130.	HIGHLOUL WAS U HUSIZU TO AL				
	_,,,,					
		Incident Review Report				
	completed by RN #5	5 and dated 01/05/2018				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 115 Continued From page 99 V 115 recorded " ." Review of the report revealed the date and time of the incident was 01/05/2018 at 2224. 2. Closed medical record review of Resident #2 revealed a admitted to the Psychiatric Residential Treatment Facility (PRTF) /2017 as Review of the record revealed admission diagnosis included Record review revealed Resident #2 had a known history of elopement on admission and eloped from the facility on 01/01/2018. Review of admissions information titled "Clinical Evaluation/Diagnostic Assessment" dated /2017 recorded by a r revealed Review revealed the resident has Review revealed on /2017 the resident The resident was . Review of a Comprehensive Psychosocial Assessment Tool documented by on 12/19/2017 (not timed) recorded the resident

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Review of

Division o	of Health Service Regu	ılation							
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION (X3)					
WIAD LEVIA C			A. BUILDING:	A. BUILDING:					
			B. WING						
		MHL0601258	D. WING		01/17/2018				
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE 1715 SHARON ROAD WEST									
			OTTE, NC 28210						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)					
V 115	Continued From page	e 100	V 115						
	admission orders dat	ted 2017 revealed the							
	resident was placed								
		ervation checks. Review of a							
	nursing note docume								
	01/05/2018 at 2030 r	evealed the resident							
	Notes recorded	d							
	110100100100								
	) 1 1	. Review							
	revealed an order wa								
	the medication was r	not administered because							
	. Review of the	emergency restrictive							
		the resident remained							
		igh 2040. Nursing notes							
		n 01/05/2018 at 2130							
	recorded								
	Notes recorded	<u>.</u>							
		. Notes revealed the							
	legal guardian was n								
	dated 01/05/2018 (n	evealed a telephone order							
	dated 0 1/05/2016 (1)	ot timed) to							
	Review of an Observ	vation Sheet dated							
	01/05/2018 the resid								
		evealed from 1600 through							
j	2345 the resident's l	ocation was left blank.							
	Review of a Health I	ncident Review Report for							
		1/05/2018 at 2030 revealed							
			,						
		) <sup>M</sup>							
	0.0								
	Open medical recrete revealed a	cord review of Resident #8 admitted to the							
1	i evedieu d	aumited to the							

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. Review of the record revealed the admission diagnosis was

on 01/09/2018 revealed a admitted to the PRTF on

. Record review revealed Resident #3 had a known history of elopement on admission and eloped from the facility on 01/01/2018. Review of a "Therapy Services

4. Closed medical record review of Resident #3

/2017 as a

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Note" written on 01/03/2018 at 1132 revealed

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 115 V 115 Continued From page 102 ..." Review of a nursing note dated 01/05/2018 at 2330 revealed " ..." Review of a nursing note by RN #5 on 01/05/2018 at 2200 revealed ..." Review of physician orders dated 01/05/2018 at 0320 revealed .." Review of a nursing note dated 01/06/2018 at 0130 revealed ..." Review revealed Resident #3 was Review of a Health Incident Review Report dated 01/05/2018 at 2030 revealed '

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON	STRUCTION	(X3) DATE SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL0601258	B. WING		04/47/2049
		MHL0001256			01/17/2018
NAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, Z	IP CODE	
		1715 SE	ARON ROAD WEST		
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	OTTE, NC 28210		
				DECLEDED OF AN OF CORDESTION	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI	
				DEFICIENCY)	
V 115	Continued From page	e 103	V 115		
	5. Review on 01/11/	2018 of the medical record of			i
	Resident #9 revealed				
	admitted on 2007/20	17 to the facility due to			
	admitted on	of to the facility due to			
		. Review of the			
	Intake Assessment d				
		isk for elopement with a			
	history of	." Record review revealed			
		nown history of elopement on			
	admission and elope				
		revealed Resident #9 was			
	not placed on elopen				
		f the Nursing Shift Note			
	dated 12/31/2017 rev	vealed Resident #9 had			
		sident #9 lived on the			
	hall. Review of a phy				
	01/02/2018 revealed	Resident #9 was placed on			
		. Review of a nursing shift			
		18 at 2200 revealed Resident			
	#9 was				
	. Reside	nt #9 was			
		. Resident #9 was			
		18 of the Health Incident			
	Review Report dated	d 01/05/2018 revealed			
l	Resident #9				
	Additional review rev	vealed Resident #9			
	6. Open medical red	ord review on 01/10/2018 for			
	Resident #10 reveal				
		chiatric Residential Treatment			
	Facility (PRTF) from				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		01/17/2018
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	
TDATEG	IC BEHAVIORAL CENTE	TR-CHARLOTTE 1715 SH	ARON ROAD WES	т	
TRATEG	COLINATIONAL CENT	CHARLO	OTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLET
V 115	Continued From pag	e 104	V 115		
	/2017 with a di	agnosis of			
		ecord review revealed			
		known history of elopement			
		oped from the facility on			
	01/01/2018. Review	of the nursing notes  10 arrived on the PRTF unit			
		nursing notes revealed the			
	resident was resident was , with no complaints of pain or discomfort. Review of the				
	•	ed the resident had old			
	injuries noted to	<u> </u>			
	Admission vital signs	s were			
		. Review			
	of the intake assessi	ment revealed the resident			
	was currently				
		ew of the intake assessment			
		ition of elopement risk related			
	to	of nursing notes dated			
		revealed Resident #10			
	PI CONTRACTOR OF THE PI				
	" Review of	telephone order dated			
		d revealed an order to			
	**				
		w of a 7pm-7am nursing shift			
	note dated 01/06/20	18 at 0130 revealed "			
		T. Daview of or Observation			
	Shoot dated 01/05/0	." Review of an Observation 2018 revealed the resident			
	was assigned to Ro				
	Review of the Obse				
		d every 15 minute checks			
	were recorded from	0000 through 2345. Review			
	revealed the resider	nt was located at "			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONS		(X3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		01/17/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE, ZI	PCODE	
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	ARON ROAD WEST OTTE, NC 28210		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
V 115	Continued From page	105	V 115	•	
	notes recorded by Mitwas "  Review of an Observe 01/06/2018, 01/07/20 the resident was assi 01/06/2018, 01/07/20 of the Observation St 01/07/2018 and 01/07 minute checks were r 2345. Review reveal at "  Review of a Health In completed by RN #1 recorded "	Review of the night shift HT #16 revealed the resident ation Sheet dated H8 and 01/08/2018 revealed gned to Room 104A on H8 and 01/08/2018. Review heet dated 01/06/2018, B/2018 revealed every 15 recorded from 0000 through hed the resident was located  acident Review Report hand dated 01/05/2018  Review of the report			
		d time of the incident was			
	a Comprehensive Ps completed by 1703 revealed the pa revealed Resident # elopement on admis facility on 01/01/2018	Review of sychosocial Assessment Tool on 10/19/2017 at atient had a			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING			
	MHL0601258	B. WING		01/17/2018	
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
STRATEGIC BEHAVIORAL CENTER	P-CHARLOTTE 1715 SH	IARON ROAD WEST	•		
STRATEGICBENATIONALCENTE	CHARL	OTTE, NC 28210			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
V 115 Continued From page	106	V 115			
Observation Sheet da	ated 01/05/2018 revealed				
	ks were documented from				
	Review revealed the resident				
was located at '	" from " ;				
then "from" from	; then "				
from	. Review of				
Night shift notes reco	rded by MHT #16 revealed				
<u> </u>					
*					
•••					
Review on 01/16/201	8 at 1435 of the 100, 200,				
and 300 hall video me					
01/05/2018 revealed:	:				
Residents	wearing				
	yers of clothing and / or				
jackets between 2010					
2010: Resident	were on the				
	00 hall door. MHT #11, #12, the 100 hall with MM#8 and				
#10, #16, and #26 in	the 100 han with white				
	and RN #27 escorted				
	) from the 100 hall	1			
	The 100 to 200 hall door				
	sident charged the door.				
MHT #18 and #26 pr	evented Resident #1 from				
entering the 200 hall.					
	d the 200/100 hall door and				
Resident	ged the door and entered the				
	#16, and #26 entered the 200			1	
hall with the resident	-				
2016: Resident	were escorted back				
from the 200 hall bad					
	as in a manual hold by MHT				
#18 on hall. Res	sident was pacing the 200				
	200 hall doors. MM #8 was				
walking around with					
2024: Resident	had broken DVDs				

6899

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 115 Continued From page 107 V 115 and were attempting to cut their arms with broken DVDs on the 100 hall. MHT #26 took the broken DVD's away from them. 2029: Resident escorted from the 200 hall back to the 100 hall 2032: Resident was placed in a manual hold by MM#8 on 200 hall. RN #1 was observing the manual hold. Resident was escorted back to the 100 hall from the 200 hall by MHT #16 and 2032: Resident came into the hall way from the 100 hall dayroom with a wooden board. 2033: MHT #26 took the wooden board from Resident 2033: MHT #16 entered the 200 hall and Resident charged the door to the 200 hall and entered the 200 hall from the 100 hall. 2034: MHT #18 released Resident #1 from a manual hold in the 200 hallway. 2035: Resident walked towards MM#8 who was manually holding Resident on the 200 hall. MHT #18 placed Resident in a manual hold. LPN #6 entered the 200 hall from the 100 hall and Resident charged the door and entered 200 hall. 2035: Resident escorted from 200 hall back to the 100 hall by LPN #6. Resident MHT#18 who was holding Resident 2036: Resident was released from a manual hold on the 200 hall. 2037: Resident walked toward Resident who was being manually held by MM#8 on the 200 hall. 2039: Resident was in the 100 hall dayroom and pulled a wooden board from a chair and went into the 100 hallway. LPN #6 escorted Resident from the 200 hall back to the 100 hall. 2040: MHT #11 took the wooden board from Resident and placed it in the bin closet on the

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SU	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
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		MHL0601258	B. WING		01/17	7/2018
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STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE				
		CHARLO	TTE, NC 28210			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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			100			
V 115	Continued From page	e 108	V 115			
	100 hall. MHT #16 es	corted Resident from	Transport of the Control of the Cont			
	the 200 hall back to the 100 hall.  2041: Resident kicked the window in the 100		To Control of the Con			
Control of the Contro	hall dayroom multiple					
		ntered the 100 hall dayroom	Patricia			
		and was hitting the window				
		ent was fitting the window	A. A. SERVICE STATE OF THE SERVICE STATE STATE OF T			
			Vision and the state of the sta			
	wooden board by Resident and also hit the window. Review revealed no staff were present		55 A S S S S S S S S S S S S S S S S S S			
	·		CPR TO SECOND			
	at this time.  2043: Resident had a chair from the 100 hall					
	•	arging the 100/200 hall door				
	with the chair.	d a DVD and was				
	2045: Resident ha					
		arm with the broken DVD in				
		. MHT #17 took DVD away				
	from Resident	contact back to 100 ball from				
		corted back to 100 hall from				
		nall dayroom Resident got				
	•	board from the chair and				
	entered the 100 hall.	den benedict		V 512		
	2049: A piece of woo	den board w		Failure to secure unit doors betwe	en units	
				and providing the supervision nece		
V 512	27D .0304 Client Rig	hts - Harm, Abuse, Neglect	V 512			
				ensure the health and safety of PR		
	10A NCAC 27D .0304	4 CLIENT RIGHTS.		residents and staff resulting in pati	ient	
	PROTECTION FROM	И HARM, ABUSE,		elopements and staff assault for 10	0 of 10	
	NEGLECT OR EXPL	OITATION		sampled patients that eloped (#1,		
	(a) Employees shall	protect clients from harm,		#11, #7, #12, #9, #10, #8, #3, and #		
	abuse, neglect and e	xploitation in accordance				
	with G.S. 122C-66.			Failure to communicate resident's	-	
	(b) Employees shall	not subject a client to any		of elopement and history of violen	t	
	sort of abuse or negle	ect, as defined in 10A NCAC		behaviors, failure to implement po	licies	
	27C .0102 of this Cha	apter.		and practices leading to destruction		
		s shall not be sold to or		equipment and patient elopement		
	purchased from a clie			equipment and patient elopement		
	established governin	, -				
	_	use only that degree of force		The following corrective actions ar	e being	
	necessary to repel or			taken to address the identified issu	ues:	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMPLI	
		<b>M</b> HL0601258	B. WING		01/1	7/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE		
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	RON ROAD W			
		CHARLOT	TE, NC 28210	)		
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V 512	aggressive client and governing body policy is necessary depends characteristics of the and physical and mer of aggressiveness disintervention procedum Subchapter 10A NCA (e) Any violation by a (a) through (d) of this dismissal of the employed or eview, police relog review and staff in neglected to ensure the for 10 of 10 sampled providing the supervishealth and safety of Presulting in patient eld for 10 of 10 sampled presulting in patient eld for 10 of 10 sampled presulting in patient eld for 10 of 10 sampled presulting in patient eld for 10 of 10 sampled presulting in cluded Review on 01/09/201 Purple" last Reviewed "Policy: To correctly in the event of a Code Pemergency)1. A groon each shift to be a president is exhibiting such code Purple with walkie-talkie with the	which is permitted by  The degree of force that supon the individual client (such as age, size stal health) and the degree splayed by the client. Use of es shall be compliance with C 27E of this Chapter. In employee of Paragraphs Rule shall be grounds for oyee.  The safety of PRTF residents with doors between units and sion necessary to ensure the error residents and staff opements and staff assault patients that eloped (#1, #2, 1, #8, #3, and #6).  The safety of Policy title "Code deliversed 12/2016 revealed dentify steps to be utilized in	V 512	Root cause (contributing factor):  1)Criteria for admission did not exclue patients with history of aggressive be elopement, or pending legal charges  (a) The criteria for admission to the PR SBC Charlotte have been revised to not exclude patients with history of felonic behavior, history of elopement from a history of gang involvement, history or substance abuse disorder, and history conflict or affiliate relationship with a resident of SBC Charlotte. Attachment shows the revised criteria for SBC, Chap RTF. SBC Charlotte is currently evaluates these same criteria will be applied to pwithin the acute care setting.  (b) Date of Completion:  Approved by the Governing Board 01/and now in place for PRTF units.  (c) Responsible Person: Chief Executive Monitoring Procedure to Ensure Corrections.  (a) (1) All admissions will be reviewed Admissions Coordinator and the CEO fevidence of compliance with exclusion criteria.  (a) (2) On a weekly basis, SBC, Charlotte conduct a PRTF Performance Improve (PI)Committee meeting. A Governing is Member will be a weekly participant to the results presented at this meeting. Attachment "B" delineates the standing for this meeting.	havior,  ATF for ow ous facility, for a current of a current of a current of a currents of 26 /2018  The Officer of a current of a curr	

at the announced location and take direction and

	of Health Service Regu	Ţ			<del></del>	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S	
ANDFLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	B:	COMPL	EIED
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
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STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE CHARLO	TTE, NC 2821	10		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NI	0/5
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				DEFICIENCY)		
\/ 512	V 512 Continued From page 110		V 512			
V 012	Continued From page	= 110	V 312	(b) Date of Completion:		
	cues from the primary	staff member on the scene		Approved by the Governing Board 01/26	/2018	
	9. The primary sta	ff member on the team will		and now in place for PRTF units.	, 2010	
		vith the RN to de-escalate				
		ed on the level of danger to		(c) Responsible Person: Chief Executive O	fficer	
	i .	ry staff and RN will cue the		(c) nesponsible verson enter executive e	111001	
		embers into position if there		(d) Monitoring Procedure to Ensure Corre	ection:	
	•	restrictive intervention"		1)		
	,			(a) (1) All admissions will be reviewed by t	:he	
	Review on 01/09/201	8 of policy title "Position		Admissions Coordinator and the CEO for e		
		d Nurse" Date Approved:		compliance with exclusionary criteria.		
	01/31/2015 revealed	• •		(a) (2) On a weekly basis, SBC, Charlotte v	vill conduct	
	NurseMay assume	=		a PRTF Performance Improvement (PI)Cor		
		assigned licensed nursing		meeting. A Governing Board Member will		
		i.e. assignments, monitoring		weekly participant to hear the results pres	sented at	
	-	/-through and high acuity		this meeting. Attachment "B" delineates t		
	directionEffectively			agenda for this meeting.		
	participate in a psych		All the second s			7
		itic Milieu 2. High visibility		One of the indicators for review will be co	mpliance	
	-	ity and takes an active role		with the exclusionary criteria for all prosp		The state of the s
	with indicated interve	*		admissions. The results, conclusions, and		
	with indicated interve	110013		recommendations will be forwarded by th		
	Paviou on 01/10/201	8 of the facility policy titled		of Quality/Compliance/ Risk to the Hospit	al's	
	"Elopement" reviewed		laminos de la companya de la company	monthly Quality/PI Council, Medical Execu		
	•	tain a safe and secure	- PER PARENTA AND AND AND AND AND AND AND AND AND AN	Committee and Governing Board at each		
		all clients receiving inpatient	00.0	respective meetings. This process will con		
	treatment. Procedure	• .		presented on a go-forward basis and has r	no end	
	elopement, the code,		MINISTER AND	date.		
		inced over the intercom, 2.				
		epartment immediately. Give		Root cause (contributing factor):		
		Have a description of the	TO A STATE OF THE	2)Patient details of prior history were no		2/18/18
		-	School-Perform V-1	present at the time of the initiation of the	e	2,10,10
		e, height, weight, sex, and	Manual Control of Cont	treatment plan and, thus, incorporated in	nto same.	
		arrive give a copy of the from the chart. 3. The RN	Anna anna anna anna anna anna anna anna	(-)2)(1)) A b   - 55 5		
		y the client's physician, the	AND THE RESIDENCE OF THE PARTY	(a)2)(1)) A hand-off form and formalized p		
		•	THE REAL PROPERTY AND ADDRESS OF THE PERSON	have been developed for implementation		
		Administrator on Call, and	S. C.	Charlotte, whereby, before a patient is rec		
		dian6. When the resident	4.00	nursing unit from the intake admission are	•	
		I notify the physician for a	THE PROPERTY OF THE PROPERTY O	Intake Assessor will verbally speak to the		
		ther the resident is to be	agroupe or the state of the sta	nurse to communicate an overview of the		
	i .	rgency Department prior to		history, condition, and all precautions. Th	ese	
	return to the facility. 7	7. The client will immediately				

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Division	of Health Service Regu	lation			,	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE				
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(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGOLATORY	ESCIDENTI TING IN ORNIATION,	IAG	DEFICIENCY)	.,	
V 512	Continued From page	e 111	V 512	and the form of the form of		
				precautions shall be written on the form e		
		ent precautions and the		"High Risk/High Alert Hand-off" and must		
		ill be consulted for any		to the receiving nurse for their acknowled		
	further orders."			and signature of same. Report on precauti		
				be provided verbally (in person or per tele		
		8 of the facility policy titled		the receiving Unit nurse prior to the patien		
	"Elopement Precaution			integrated into the nursing unit environme		
		Residents who talk of		Unit nurse, in turn, will be responsible for		
	running away, particip	pate with or know of a		implementing all orders and processes that		
	planned runaway or a	actually run away will be		accompany the specific precautions. Attac		
	placed on elopement	precautions Procedure		delineates the hand-off form and associat		
	2. The adolescent v	who returns from an		During daily Administrator on Call rounds,		
	elopement must write	a detailed narrative		will check the 15-minute check sheets for		
	describing the events	prior to the run, the run		of appropriate stickers signifying patient s		
	itself, and what transp	pired while the resident was		precautions that must correspond with th		
		must complete prior to the		precautions identified by the High Risk/High		
	client being removed	•	Australia Parasas	Hand-Off and, as ordered by the patient's		
	_	rative should include an		Deficiencies noted will be immediately co		
	'	alternative manner of coping,	de fundos e osos	Staff not meeting these requirements will addressed on a progressive disciplinary ba		
		vay. 3. Adolescents on		addressed on a progressive disciplinary ba	.515.	
	_	ns will have a bedtime of				2/10/10
	8:30 pm every night.			a)(2) A patient safety notification system h	nac heen	2/18/18
	, , , ,	rs to use as footwear. No		developed whereby all patients on the PR		
		ed. 5. Residents will not be	5	having identification stickers that are colo		
		unit. 6. The individual's		with level of precautions placed on their 1		
		modified to reflect the		round sheets. According to this system, b		
		ary to maintain safety, i.e.		their identified safety need, patients will h		
		nited phone calls. 7. A		yellow, or green level of precaution assign		
		be required to remove the		example, patients on elopement precaution		
		ent precautions. 8. Criteria		identified on their 15-minute check sheet		
		n elopement precautions		and staff must ensure that they adhere to		
		is behavior to self or others,		provisions of the Elopement policy includi		
		ous behavior, compliance	1	restriction on outdoor activities, as ordere	-	
	-	is, the willingness to talk with		patient's physician. Attachment "D" deline		
	staff regularly about of	_		new process for patient safety notification		
	stall regularly about C	concerns/rectings.		During daily Administrator on Call rounds,		
	Paviou on 01/11/201	8 of the facility policy titled		will check the 15-minute check sheets for		RESIDENCE STATE OF THE PROPERTY STATE OF THE
	"Admission Procedur	8 of the facility policy titled				
						TO TO THE T
		.B. Belongings are to be				0.00
	itemized on the belor	nging list when brought to the				

unit ...C. Patient may keep at bedside a

PRINTED: 02/07/2018 FORM APPROVED

NAME OF PROVIDER OR SUPPLIER  STRATEGIC BEHAVIORAL CENTER-CHARLOTTE  (PAC) ID (SUMMARY STATEMENT OF DEPICIENCES THAT AGE (SEA DEPICE) AND SHOULD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG (SEA DEPICE) AND SHOULD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG (SEA DEPICE) AND SHOULD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG (SEA DEPICE) AND SHOULD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG (SEA DEPICE) AND SHOULD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG (SEA DEPICE) AND SHOULD BE (COMPLETE DATE DEPICIENCY)  V 512  V 512  Continued From page 112  reasonable amount of clothing after a thorough contraband and safety search. Clothing with drawstrings and other potentially hazardous items will not be allowed"  Review on 01/12/2018 of the facility policy titled "Fifteen Minute Checks / Intervention Log" reviewed/revised 12/2016 revealed "Policy. The client is observed at minimum, every fifteen minutes by a designated staff member to monitor for safety, behavioral changes and to indicate client locationS. Staff will document the client's location on the observation sheet every 15 minutes"  Review on 01/12/2018 of the facility policy titled "Documentation" reviewed/revised 12/2016 revealed "Policy. Nursing documentate the client's location on the observation sheet every 15 minutes"  Review on 01/12/2018 of the facility policy titled "Documentation" reviewed/revised 12/2016 revealed "Policy. Nursing documentate to lient's location on the observation sheet every 15 minutes"  Review on 01/12/2018 of the facility policy titled "Documentation" reviewed/revised 12/2016 revealed "Policy. Nursing documentate of the client's location and progress and by the client, Procedure Assessment of a client's current status of the client's current condition and progress in treatment is an ongoing process and will be documented by the nurse according to any status changes 3. The	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  STRATEGIC BEHAVIORAL CENTER-CHARLOTTE  (X4) ID SUMMARY STATEMENT OF DETRICIPACIES I CHARLOTTE, NC 28210  V 512  Continued From page 112  reasonable amount of clothing after a thorough contraband and safety search. Clothing with drawstrings and other potentially hazardous items will not be allowed"  Review on 01/12/2018 of the facility policy titled "Fifteen minutes by a designated staff member to monitor for safety, behavioral changes and to indicate client location5. Staff will document the client's minutes"  Review on 01/12/2018 of the facility policy titled "Documentation" reviewed/revised 12/2016 revealed "PolicyThe client sobserved at minimum, every fifteen minutes by a designated staff member to monitor for safety, behavioral changes and to indicate client location5. Staff will document the client's minutes"  Review on 01/12/2018 of the facility policy titled "Documentation" reviewed/revised 12/2016 revealed "PolicyThe client sobserved at minimum, every fifteen minutes by a designated staff member to monitor for safety, behavioral changes and to indicate client location5. Staff will document the client's location and progress in treatment is an ongoing process and will be documented by the client. Procedure2. Assessment of a client's current condition and progress in treatment is an ongoing process and will be documented by the nurse according to any status changes 3. The	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPLE	TED
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		nurse according to ar	ny status changes. 3. The		I and the second		
Nurse will documentsummary documentation Deficiencies noted will be immediately corrected.		Nurse will document	summary documentation		Deficiencies noted will be immediately co	rrected.	
will be completed every seven daysincident  The findings will be summarized at the Hospital's					•		
charting will be completed. The weekly/ daily  Morning Meeting of leadership staff. The findings		charting will be comp	leted. The weekly/ daily		Morning Meeting of leadership staff. The	findings	
nursing notes will include the individual response will be aggregated and reviewed at the weekly PRTF					will be aggregated and reviewed at the w	eekly PRTF	
to meds, any side effects and relevant lab values.  PI Committee. A Governing Board Member will be a					PI Committee. A Governing Board Memb	er will be a	
4. Incident charting includes any circumstances weekly participant to hear the results presented at					weekly participant to hear the results pre	sented at	
involving the client, which indicate an immediate this meeting. The findings, conclusions,		-			this meeting. The findings, conclusions,	The second secon	
or unexpected change of status. Some examples recommendations, and actions will be		_			·		
includeinjuries, special treatment procedures forwarded by the Director of			•				
and self-abusive behaviors. 5. Summary  Quality/Compliance/Risk to the Hospital's monthly			•				
documentation is directed at recording progress  Quality/PI Council, Medical Executive Committee and			-				
toward achieving the measurable treatment plan  Governing Board at each of their respective		1	<del>- · -</del>		Governing Board at each of their respecti	ve	
goal. Summary documentation should include meetings. This process will continue as presented on		_	·			esented on	
Client's mental status, physical status, behavior					a go-forward basis and has no end date.		
in the therapeutic milieu, mood, affect, medication							

PRINTED: 02/07/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Root cause (contributing factor): V 512 V 512 Continued From page 113 3) Information of incoming patients and prior compliance and response, appetite and intake, placements with other patients was not percent of weight gain or loss, grooming and always known to the facility. History of hygiene, quality of sleep, nursing interventions, patterns of elopement and history of violent current nursing care being provided, and any behaviors were not always communicated. restrictive interventions needed ...7. Staff will (a)Part of the guery of the intake assessment document the client's location on the observation now compares prior placements of prospective sheet every 15 minutes ..." residents to those residents currently in house. If there is evidence learned of a prospective Review of a local "Police Department Incident resident having resided at the same facility of a Report" revealed the police were called on current resident, a further inquiry regarding 01/01/2018 at 2156 to assist with an assault to MHT #10, property damage and ten missing relationship between the two will be obtained persons listed as Resident #8 ( and documented before accepting the new Resident #9 ( resident. Prospective residents with Resident #2 ( Resident #10 ( determined histories of conflict with a current Resident #1 resident or having affiliated with a current Resident #6 ( Resident #11 resident will be excluded from admission. Resident #12 ( All intake assessment staff are being trained Resident #3 ( and through inservice activities on these Resident #7 ( requirements. In order to remain on the schedule, staff not in attendance for the A.1. Open medical record review on 01/09/2018 inservice are required to receive training on this for Resident #1 revealed a requirement prior to any scheduled work by the admitted to the Psychiatric Residential Treatment completion date. /2017 with diagnoses of Facility (PRTF) on Staff not meeting these requirements will be Review of the addressed on a progressive disciplinary basis. intake assessment revealed the resident (b) Date of Completion: Approved by the Admission Governing Board 01/26/2018 vital signs were and now in place for PRTF unit (c) Responsible Person: Chief Executive Officer

Division of Health Service Regulation

STATE FORM

Psychiatrist Evaluation documented on

/2017 at 2050 revealed "

Review of the

V3NZ11

(d) Monitoring procedure to ensure correction

3)(a) All (100%) admissions to the PRTF will be

reviewed by the Admissions Coordinator and the CEO for evidence of compliance with this review and application of exclusionary criteria for residents with history of conflict or an

On a weekly basis, SBC, Charlotte will conduct

affiliation with a current resident.

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL0601258	B. WING		01/17/201	18	
	ROVIDER OR SUPPLIER	R-CHARLOTTE 1715 SH	DDRESS, CITY, S' ARON ROAD W DTTE, NC 2821	VEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COM	(X5) MPLETE DATE	
V 512	Further review of the Assessment Form" di Resident #1 had the violence: "  medical record review available to determintreatment plan to addelopement and patter the medical record refor Residual 1048-1053 for destruin, a 1628-1638 for 1628-1638 for 1620-17 from 210 video recordings on 0 hallways on 01/1/201 fully dressed in 17 Review of the record dated 01/01/2018 at 2 minutes.	"Admission Intake ated	V 512	a PRTF Performance Improvement (PI)Committee meeting. A Governing member will be a weekly attendee. Indicators for review will be compliant the exclusionary criteria. The results forwarded by the Director of Quality/Compliance/ Risk to the Hosymonthly Quality/PI Council, Medical Committee and Governing Board at their respective meetings. This procecontinue as presented on a go-forwal and has no end date.  Root cause (contributing factor): 4)The treatment plans did not alway individualized patient information is elopement history, violence history, strategies to prevent. An audit for sonot in place to identify deficient ent (a)(1) All staff with responsibility for of the treatment plan ae being instruthrough inservice education on the requirement to include all patient into that will be necessary to formulate a initial treatment plan for the residen Information shall include elopement violence history, suicide precautions precautions that may impact the resistaff. Compliance with this responsible evaluated daily (M-F) as part of the Morning Leadership meeting (see mosection for description). Deficiencies be updated within one hour of disconnot meeting these requirements will addressed on a progressive disciplinal In order to remain on the schedule, sattendance for the inservice are required receive training on this requirement any scheduled work by the completic	One of the nee with will be pital's Executive each of ess will rd basis  ys reflect neluding and ame was ries. completion acted  formation n effective t. and any ident's ents and oillity will be dospital's conitoring noted will very. Staff be eary basis. Staff not in aired to prior to	3/18	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: \_\_\_\_\_

(X3) DATE SURVEY COMPLETED

MHL0601258

B. WING \_\_\_\_\_

01/17/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TRATEG	IC BEHAVIORAL CENTER-CHARLOTTE	ARON ROAD W OTTE, NC 2821		
(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) COMPLET DATE
V 512	Continued From page 115	V 512	Staff not meeting these requirements for use of the treatment plan to individualize the patient's precautions and associated plan of care will be addressed on a progressive disciplinary basis.	
To a constitution of the c			(b)(1) Date of Completion: 02/18/2018	
			(c)(1) Responsible Person: Director of Clinical Services	
	Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room on 01/01/2018.		a)(2) All staff with responsibility for completion of the treatment are being instructed that with patient events including restrictive interventions, elopement attempts, suicide gestures, aggressive acts, and changes in patient condition, that they are to update	
	Review of the Observation Sheet dated 01/01/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at		the treatment plan to reflect any new precautions and individualized plan of care to ensure the resident's safety and the safety of any other residents and staff.	
	Review of the Observation Sheet dated		In order to remain on the schedule, staff not in attendance for the inservice are required to receive training on this requirement prior to any scheduled work by the completion date.	
	01/02/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at  Review of the night shift		Staff not meeting these requirements for use of the treatment plan to update the patient's precautions and associated plan of care will be addressed on a progressive disciplinary basis.	
	notes recorded by MHT #16 revealed the resident was ' (minutes). Resident physically attacked staff		Compliance with this responsibility will be evaluated daily (M-F) as part of the Hospital's Morning Leadership meeting (see monitoring section). Deficiencies noted will be updated within one hour of discovery. Staff not meeting these requirements will be addressed on a progressive disciplinary basis.	
	Review of the medical record on 01/09/2018		(b)(2) Date of Completion: 02/18/2018	
	revealed no documentation of a nursing assessment in the record after the resident was returned from elopement. Review of the record		(c) (2) Responsible Person: Director of Clinical Services	

Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) (d)Monitoring procedure to ensure correction V 512 V 512 | Continued From page 116 4) (a) (1 and 2) A 100% audit of treatment on 01/11/2018 revealed a nursing note plans will occur daily(Monday through Friday documented by RN #5 dated 01/02/2018 at 0015 with the results of Friday, Saturday, and Sunday that recorded the resident returned to the facility incorporated into Monday's report) against the . Note recorded that resident's "High Alert Notification " list and progress notes and incident reports related to resident events that have occurred including acts of violence, elopement attempts, suicide attempts/gestures, acts of aggression, changes in the patient's condition, and any events that may impact the resident's safety and the safety Review of nursing note dated 01/02/2018 at 1430 of other residents and staff. The purpose of the revealed " audit will be to assess if the risks were initially captured as part of the treatment plan and if Review of post event, the treatment plan been updated to telephone orders dated 01/02/2018 not timed reflect events or changes in the patient's revealed orders to place Resident #1 on condition. The findings of this audit will be for and reported at the Morning Meeting of Hospital upon return to Leadership Staff, Monday through Friday. facility. These findings will be aggregated and presented on a Review of physician orders dated 01/02/2018 at weekly basis to the newly formed SBC, 2050 revealed a telephone order for Charlotte PRTF PI Committee. A Governing Board member shall be an attendee of that as needed for meeting to hear the results and actions. The of a Case Management Note documented by the Director of Clinical Services (DCS), dated findings, conclusions, recommendations, and 01/02/2018 and signed as "Late Entry" on actions taken will be forwarded by the Director 01/03/2018 at 1700 revealed she met with the of Quality/Compliance/Risk to the Hospital's client, the Director of Nursing (DON) and the monthly Quality/PI Council, Medical Executive Milieu Manager (MM) after the resident was Committee and Governing Board at each of returned to the facility their respective meetings. This process will Note recorded the DCS and the DON questioned continue as presented on a go-forward basis client about any injuries, pain or other concerns. and has no end date. Note recorded the DCS set expectations for resident's return to the unit. Note recorded the client was assessed by a Registered Nurse (RN).

Division of Health Service Regulation

01/04/2018 at 1237 revealed "

Review of the Psychiatrist progress note dated

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Root cause (contributing factor): Meeting V 512 Continued From page 117 5) The prior CEO had erroneously communicated to with Police staff to not involve the Police in patient situations. 1/17/18 (a) All Hospital staff are now receiving training specific to the expectation that the Charlotte Police Trng and Department is to be called if there is a patient re-trng on situation that is unable to be managed by personnel policy on site. It has been further clarified that the on-site completed Supervisor or Charge Nurse is empowered to contact 2/18/18 the Police Department and does not have to have approval by any off site administrative staff to do so. Attachment "E" delineates this policy that is in effect. A meeting was held with the Charlotte Police Review of a Health Incident Review Report for Department to discuss the appropriateness of Resident #1 completed by RN #2 and dated contacting them and to ensure their agreement that 01/01/2018 recorded " in situations that cannot otherwise be handled by staff and that may impact the safety of staff or residents that the police may be contacted for assistance. 100% of key events including restrictive interventions, aggressive acts of patients to patients and patients to staff, and reports of staff perceptions Review of the report revealed the date of lack of adequate staff to handle a patient situation and time of the elopement was 01/01/2018 at will occur daily (Monday through Friday with the results of Friday, Saturday, and Sunday incorporated into Monday's report) will be reviewed to assess if Review of a Health Incident Review Report for the Police were contacted, when indicated and, if Resident #1 completed by RN #4 on 01/02/2018 not, the reasons for same. Re-training and recorded " reclarification of the use and contact of the Charlotte Police Dept. will occur. Staff not meeting these requirements after retraining will be addressed on a progressive disciplinary basis. Review of a Health Incident Review Report for Resident #1 completed by RN #5 and dated 01/02/2018 recorded "(

Division of Health Service Regulation

PRINTED: 02/07/2018 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) b) Date of Completion: V 512 Continued From page 118 V 512 Meeting with Charlotte Police Dept.: 01/17/2018 Completion of training on policy for all SBC Charlotte staff: Review of the report revealed 02/18/2018 the date and time of the incident was 01/02/2018 at 1321. (c) Responsible person: Director of Compliance/Quality/Risk Review of the Medication Administration Record (d) Monitoring procedure to ensure correction revealed no available documentation of administered on 01/02/2018. Review of Compliance will be monitored as follows: Restrictive Intervention documentation dated A 100% review of key events including restrictive 01/02/2018 at 1321 revealed a physician order for interventions, aggressive acts of patients to patients for resident and patients to staff, and reports of staff perceptions of lack of adequate staff to handle a patient situation will occur daily (Monday through Friday with the results of Friday, Saturday, and Sunday incorporated into Monday's report) to assess if the Police were Restrictive intervention documentation revealed contacted, when indicated. The findings of this Resident #1 was placed in review will be reported at the Morning Meeting of on 01/02/2018 at 1321, then Hospital Leadership Staff, Monday through Friday. at 1322 and at 1342. Restrictive These findings will be aggregated and presented on a Intervention documentation revealed Resident #1 weekly basis to the newly formed SBC, Charlotte was administered PRTF PI Committee. A Governing Board member at 1326. shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, Interview on 01/12/2018 at 1015 with RN #5 recommendations, and actions taken will be revealed Resident #1 was forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Resident #1 had a Medical Executive Committee and Governing Board at each of their respective meetings. This process will continue as presented on a goforward basis and has no end date. Interview on 01/12/2018 at 1015 with RN #5

Division of Health Service Regulation

revealed Resident #1 was admitted to the 200 hall due to elopement risk. Interview revealed we

Interview revealed we

Division o	of Health Service Regu	ulation			FORI	MAPPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE S COMPL	
		MHL0601258	B. WING		01/1	17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE		
0704750	IO DELLA MODAL CENTE	1715 SH	ARON ROAD V	VEST		
STRATEG	STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHA			0		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	JST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETE DATE
V 512	Continued From page 119  Resident #1 said Interview revealed from that point forward Resident #1 and Resident #2 were not to be on the same hall together.  Closed medical record review of Resident #2 revealed a admitted to the Psychiatric Residential Treatment Facility (PRTF) on /2017 as Review of the record revealed admission diagnosis included  Review of admissions information titled		V 512	Root cause (contributing factor): 6) There was no prior experience of vectors are also prior experience of vectors.	to take	2/18/18 all elements
				(a) A Riot Management plan was dever the Hospital. The plan delineates all a take in the event of a riot, which is de- "an act of imminent threat or violence approximately three or more persons	fined as: by acting	
				collaboratively to harm staff or other to destroy property, or escape from the Attachment "F" delineates the Riot Management Plan that was developed	ne unit".	
				All SBC Charlotte Hospital staff were t the requirements of the riot managen including the expectation to involve the early should such a patient riot, again Drills on Riot Management are occurr	nent plan ne police , occur.	
	dated /2017 rerevealed the residen	t 7 Review		monthly basis at the Hospital. The Riot Management plan and action to take has been incorporated into the Hospital's ongoing orientation.  (b) Date of Completion:		
	revealed on /20	Review 017 the resident		Approved for Implementation: 1/11/2 Completion of training on Riot Manag plan: 2/18/18 Riot management drills in place as of:	gement	
		Review of a		Content included in Hospital Orientati 02/18/2018. (c) Responsible Person: Chief Executi	ion as of:	
	Comprehensive Psy documented by (not timed) recorded	chosocial Assessment Tool on/2017 the resident"		(d)Monitoring procedure to ensure of Compliance with implementation of the Management plan, as indicated, will be monitored as follows:	he Riot be	
		e "Admission Intake dated 12/18/2017 stated following risk and history of		A 100% review of events that meet the Hospital's definition of a patient riot was reviewed daily (Monday through Fridathe results of Friday, Saturday, and Su	will be ay with	

Based on the medical record review

incorporated into Monday's report to assess if

PRINTED: 02/07/2018

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) the Riot Management plan was followed V 512 Continued From page 120 V 512 including if the Police were contacted, when there was no evidence available to determine indicated. The findings of this review will be facility staff implemented a treatment plan to reported at the Morning Meeting of Hospital address the history of elopement and patterns of Leadership Staff, Monday through Friday. violence. Review of facility video recordings on These findings will be aggregated and 01/10/2018 of residential hallways on 01/1/2018 presented on a revealed Resident #2, fully dressed weekly basis to the newly formed SBC, Charlotte PRTF PI Committee. A Governing Board member shall be an attendee of that Review of admission orders dated 12/19/2017 meeting to hear the results and actions. The revealed the resident was placed on assault findings, conclusions, recommendations, and precautions with every 15 minute observation actions taken will be forwarded by the Director checks. Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to of Quality/Compliance/ Risk to the Hospital's on 01/01/2018. Review of the monthly Quality/PI Council, Medical Executive Observation Sheet dated 01/01/2018 revealed Committee and Governing Board at each of every 15 minute checks were recorded from 0000 their respective meetings. through 2345. Review revealed the resident was This process will continue as presented on a :" (location not defined) from located at " go-forward basis and has no end date. 1/23/18 Rounds in Root cause (contributing factor): (location not defined). Review of the night shift place 7) The furniture in use at the hospital, to notes recorded by MHT #14 revealed the resident date, had never been stressed to the point 2/7/18was returned from elopement and placed on every 15 minute room checks. The notes Prototype of being broken. recorded that the resident was given an desk (a) The desks that were broken by the 2/18/18 residents and separate boards used to Review of nursing notes documented by RN #2 Trng and devise weapons were removed from the on 01/01/2018 at 1920 recorded the resident's re-trng of environment. was and was given staff on Notes recorded ' assessing Chairs containing the same design with slats that were broken off were reinforced for furniture with hardware (that, itself, cannot be compromised) to increase their strength and reduce the chance of being dismantled equipment that may through the application of force.

Division of Health Service Regulation

STATE FORM

be damaged

PRINTED: 02/07/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A prototype desk has been devised that has solid V 512 V 512 | Continued From page 121 pieces of wood that will prevent any boards from being broken off from one another. This desk has been tested against extreme force and with the single board, is unable to be dismantled to be used ." Review of the medical as a weapon. record on 01/10/2018 revealed no documentation of a nursing assessment in the record. Review All staff with patient care responsibilities are being on 01/11/2018 revealed a nursing note advised through inservice education that, when documented by RN #5 dated 01/02/2018 at 0010 furniture or other objects are being broken by a that recorded the resident returned to the facility patient to use as weapon, and such a weapon is . Notes recorded the resident was being brandished, if house staff cannot or do not feel safe in immediately bringing the situation under control, the Charlotte Police Department is to be immediately summoned for assistance. Additionally, all staff with patient care responsibilities are being advised through inservice education on the expectation to assess for the ." Record review revealed the resident was integrity of furniture in the patient care environment d and at the start of each shift and to remove and secure return to the facility on 01/02/2018. Review furniture that appears to have been compromised or revealed the resident was placed on that may pose a possible risk for being broken. upon return. Review of nursing notes documented on 01/02/2018 at 1400 recorded In order to remain on the schedule, staff not in attendance for the inservice are required to receive work by the completion date. Review of a psychiatrist progress note dated (b) Date of Completion: 01/04/2018 at 1242 recorded the patient All patient chairs reinforced to prevent being dismantled: 01/09/2018 Desks removed from resident environment and will Review of the notes revealed remain out of patient area until replacement desk is completed: 01/11/2019

Division of Health Service Regulation

STATE FORM

01/01/2018 recorded

Review of Health Incident Review Report for

Resident #2 completed by RN #2 and dated

V3NZ11

Prototype desk devised: 02/07/2018

rounds in place as of: 01/23/2018

All staff educated about expectation for the use of

the Police to assist, as presented: 02/18 /2018

System for checking status of furniture per

(c) Responsible person: Director of EOC

Division	ivision of Health Service Regulation						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPE	LE CONSTRUCTION	(X3) DATE S		
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLI	ETED	
		MHL0601258	B. WING		01/1	7/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	TATE, ZIP CODE			
		1715 SH	ARON ROAD W	VEST			
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE CHARLO	OTTE, NC 2821	0			
(X4) ID	SUMMARY ST	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		N	(X5)		
PREFIX	<b>V</b> — · · · · · · · · · · · · · · · · · ·	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE	
TAG	REGULATORTORT	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	VIATE		
	40 0 15 15			(d) Monitoring procedure to ensure corre	ection		
V 512	Continued From page 122		V 512	(4, тотто т., в резольное со ставе с ста			
				Compliance with the corrective actions wi	ll be		
				accomplished as follows:			
		." Review of		On a daily basis (M-F), the EOC Director w	ill conduct		
	the report revealed th	ne date and time of the		rounds in all resident care areas to ensure	that the		
	elopement was 01/01			furniture is secure, and that there is evide	nce of no		
	·			tampering with same. On weekends, these			
	Interview on 01/12/20	018 at 1015 with RN #5		will be accomplished by the House Superv			
	revealed Resident #1	was admitted to the 200		rounds will be augmented by MHT staff w			
	hall due to elopemen	t risk. Interview revealed we		assess the integrity of all furniture in the F			
				patient care areas prior to the start of eac	h shift.		
				Any items that appear to have been comp	ramicad ar		
				that may pose a possible risk for being bro			
		Interview revealed we		immediately removed from the environment		1	
				returned until repaired or replaced.	erre arra rroc		
	Resid	dent #1 said		Root cause (contributing factor):		2/18/18	
		riew revealed from that point		8) The medical record audit process was	not		
		and Resident #2 were not to		capturing time/date omissions, assessme			
	be on the same hall t			assessments not documented, as require			
	bo on the barrie name	ogouror.		Similarly, the performance improvement			
	3. Open medical rec	ord review of Resident #11		process was not capturing the review for			
	revealed a	admitted to the		compliance with items including treatme content against patient precautions and			
	PRTF on 0/2017	with anger		assessments per expectation.			
	issues.			(a) All SBC Charlotte Hospital leadership st	taff with		
				responsibilities within their departments			
	Further review of the	"Admission Intake		record documentation have been re-educ			
	Assessment Form" d	ated /2017 stated		specific requirements for the medical reco	ord		
	Resident #11 had the	e following risk and history of		components including: but not limited to:			
	violence: '			(1) Dating/timing of orders within require	ments		
		." Based on		(2) Frequency of documentation			
		eview there was no evidence		(3) Medications documented as ordered			
		e facility staff implemented a		(4) Completion of assessments and reasse	ssments		
	treatment plan to add	-		per time requirements			
		rns of violence. Review of		(5) Frequency of MD Progress Notes	J D + t - +		
	facility video recordir			(6) Co-signature by MD after Seclusion an within 24 hours	a Kestraint		
	-	on 01/1/2018, revealed		These items are in addition to those other	nuice noted		
	Resident #11, fully di	ressed in		in this report	MIZE HOTEO		

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL0601258	B. WING		01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		1715 SHAF	ON ROAD WE	EST	
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE CHARLOT	TE, NC 28210		
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I WES
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 512	V 512 Continued From page 123  Review of admission orders revealed the resident was placed on every 15 minutes observation and remained on every 15 minute observation on 01/01/2018. Review of an Observation Sheet		V 512	All SBC Charlotte Hospital and Medical staf responsibility for documentation have bee reminded through meetings and written m of the requirements for documentation, as	n nemoranda
				delineated above.	
	dated 01/01/2018 rev	ealed the resident was		All SBC Charlotte Hospital leadership staff	1
		on 01/01/2018. Review		responsibilities within their departments for	• •
	of an Observation Sh			record documentation have been re-education distributions and a second control of the se	1
	revealed every 15 min			medical record audit process and associate expectations for its completion.	2a
documented from 0000 through 2345. Review			expectations for its completion.		
	revealed the resident was located at "3			Staff that remain out of compliance will be	
	then 'from from	mg" from; com; then		addressed through the Hospital's progress	
	' from	; then '		disciplinary process. Medical staff remaining	
	; then '	" from """ " from		compliance will be addressed through the Staff Peer Review process.	Medical
	Review of Night shift revealed "	notes recorded by MHT #17		<b>(b) Completion Date:</b> Re-education of Hospital and Medical Staff 02/18/2018	f:
				Re-education of Hospital leaders on requir 01/31/2018	ements:
		." Review of notes		Initiation of intensified audits: 02/01/2018	
	at 2202 revealed "			(c) Responsible Person:	
				Director of Compliance/Quality/Risk	
				(d)Monitoring procedure to ensure correct a) 100% audit of medical records will occu course of the week against medical record	r over the
	." / 01/02/2018 at 0000 re	A nursing note by RN #1 on ecorded "		compliance with: (1) Dating/timing of all orders (2) Frequency of documentation	
	Nursing notes docum	." ented by RN #5 dated		(3) Medications documented as ordered (4) Completion of assessments and reasses	ssments
	01/02/2018 at 1330 re	<u> </u>		per time requirements	
		." Notes at		<ul><li>(5) Frequency of MD Progress Notes</li><li>(6) Co-signature by MD after Seclusion and within 24 hours</li></ul>	l Restraint
	2200 recorded			WIGHII 24 HOUIS	

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Root cause (contributing factor): 1/17/18 V 512 V 512 | Continued From page 124 9)False perception by staff that the police Meeting could not be called to assist when staff was with police Notes revealed the resident not, otherwise, able to obtain control of the had and residents. 2/18/18 . Notes revealed (a) All Hospital staff are now receiving training Trng of all medication was administered. Review of an LPN through inservice education specific to the note dated 01/02/2018 at 0050 recorded staff expectation that the Charlotte Police Department is to be called if there is a patient situation that is unable to be managed by personnel on site. It has been further clarified that the on-site Supervisor or Charge Nurse is empowered to contact the Police Department and does not Review of the medical record on 01/10/2018 have to have approval by any off site revealed no further documentation of a nursing administrative staff to do so (as previously assessment in the record after return from noted in Attachment "E"). elopement on 01/01/2018. Review on 01/11/2018 In order to remain on the schedule, staff not in revealed a nursing note documented by RN #5 attendance for the inservice are required to dated 01/02/2018 at 0010 that recorded receive training on this requirement prior to any scheduled work by the completion date. A meeting was held with the Charlotte Police Department to discuss the appropriateness of (LPN contacting them and to ensure their agreement that in situations that cannot otherwise be handled by staff and that may impact the safety of staff or residents that the police may be contacted for assistance. 100% of key events including restrictive interventions, aggressive acts of patients to patients and patients to staff, and reports of ." Review of a psychiatrist note recorded staff perceptions of lack of adequate staff to on 01/04/2018 at 1112 revealed "... handle a patient situation will occur daily (Monday through Friday with the results of Friday, Saturday, and Sunday incorporated into Monday's report) will be reviewed to assess if the Police were contacted, when indicated and, if not, the reasons for same. Re-training

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and reclarification of the use and contact of

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) the Charlotte Police Dept. will occur. Staff not V 512 V 512 Continued From page 125 meeting these requirements after re-training will be addressed on a progressive disciplinary basis. (b) Date of Completion: 4. Closed medical record review of Resident #7 Meeting with Charlotte Police Dept.: 01/17/2018 admitted to the revealed a Completion of training on policy: 02/18 /2018 PRTF on /2017 with (c) Responsible Person: Director of Quality/Compliance/Risk Further review of the "Admission Intake (d) Monitoring procedure to ensure correction Assessment Form" dated 2017 stated Resident #7 had the following risk and history of Compliance will be monitored as follows: A 100% review of key events including restrictive ." Based on the medical record interventions, aggressive acts of patients to patients review there was no evidence available to and patients to staff, and reports of staff perceptions determine facility staff implemented a treatment of lack of adequate staff to handle a patient situation plan to address the history of elopement and will occur daily (Monday through Friday with the patterns of violence. Review of facility video results of Friday, Saturday, and Sunday incorporated recordings on 01/10/2018 of residential hallways into Monday's report) to assess if the Police were on 01/1/2018, revealed Resident #7, fully dressed contacted, when indicated. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. Review of admission orders revealed the resident These findings will be aggregated and presented on a was placed on every 15 minutes observation and weekly basis to the newly formed SBC, Charlotte remained on every 15 minute observation on PRTF PI Committee. A Governing Board member 01/01/2018. Review of an Observation Sheet shall be an attendee of that meeting to hear the dated 01/01/2018 revealed the resident was results and actions. The findings, conclusions, assigned to Room on 01/01/2018. Review recommendations, and actions taken will be of an Observation Sheet dated 01/01/2018 forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, revealed every 15 minute checks were Medical Executive Committee and Governing Board documented from 0000 through 2345. Review at each of their respective meetings. revealed the resident was located at ' ' from from then " then ' ' from then " " from then ' from Review of Night shift notes recorded by MHT #13 revealed

Division	of Health Service Regu	lation			FORM	APPROVED
STATEMENT	FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION ::	(X3) DATE SU COMPLE	
		MHL0601258	B. WING		01/1	7/2018
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE ZIP CODE		
NAME OF T	NOVIDEN ON 3011 EIEN		ARON ROAD V			
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	OTTE, NC 2821			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETE DATE
V/ E12	O	100	V 512	Root cause (contributing factor):		
V 512	Continued From page	2126	V 512	10) Lack of questioning by staff of reside	nts who	
				were wearing multiple layers of clothing	1	
				torn and handmade bandanas (including		
				patient who reportedly had an actual bar	1	
				(a) Patients will now have a limit of three		
		Review of nursing notes		clothes at a time in their rooms and the re	mainder of	
	documented by RN #	1 dated 01/01/2018 at 2015	-	items will be stored in their patient belong	gings area	
	revealed the resident	was easily agitated by peers		(Attachment "J").		
	and offered and refus	sed prn (as needed)		(b)Staff have been apprised through Elope		
	medication for agitati	on. Review of notes at 2202		training that an indication of an impending		
	revealed '			elopement is that sometimes the resident	-	
				multiple layers of clothes or dresses in sne	akers or	
				shoes when they normally do not do so.		
				(c )Staff have been inserviced through class written memoranda on their need to quer		
				who are noted to be wearing multiple layer		
				clothing and/or exhibit a change in their		
		A nursing note by RN #1 on		items they typically wear and approach th		
	01/02/2018 at 0000 r	ecorded '		same.		
				(b)Date of Completion:		
		tes documented by an LPN		Policy change implemented 02/18/.2018		
	dated 01/02/2018 at	0130 recorded "U				
				Monitoring for compliance:		
	" None			02/18/2018		
	Nursii	ng noted				
				(c) Responsible person:		
	Nursing notes docum	nented by RN #5 dated		Director of Nursing	The state of the s	
	01/02/2018 at 1300 r			(d )Monitoring procedure to ensure corre	ection	
	5170272010 at 15001	000.404		Compliance will be monitored as follows:	CHOIL	
		"		As part of the daily unit rounds on the da	v and	
	Notes at 2200 record	ed .		evening shifts, the Director of Nursing or t	•	
	111111111111111111111111111111111111111			delegate will assess patients for the prese	į.	
				multiple layers of clothing. In addition, as		
				these daily rounds, room inspections will		
	Notes revealed the re	esident had		the PRTF to ensure that compliance is bei		
	and	. Notes		the policy on 1) three changes of clothing	per patient	
	revealed	medication was		(one set on, two available to them) and no	ot in excess	
		w of the medical record on		of same and 2) observation for multiple la	yers of	

01/10/2018 revealed no documentation of a nursing assessment in the record. Review on

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) clothing of patients. The findings of this review will V 512 V 512 Continued From page 127 be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded These findings will be aggregated and presented on a weekly basis to the newly formed SBC, Charlotte PRTF PI Committee. A Governing Board member shall be an attendee of that meeting to hear the results and actions. The findings, conclusions, recommendations, and actions taken will be forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Medical Executive Committee and Governing Board review revealed the resident was discharged on at each of their respective meetings /2018. Root cause (contributing factor): 5. Open medical record review of Resident #12 11) Staff verbalized sometimes feeling "ill revealed a admitted to the equipped" to handle the number and acuity of PRTF on /2017 with patients 2/16/18 (a) The criteria for admission has been revised to Revised exclude patients with a history of felonious behavior, Review of rounds history of elopement from a facility, history of gang a Comprehensive Psychosocial Assessment Tool questions involvement, history of substance abuse disorder, 2017 at completed by on and history of a conflict or affiliate relationship with in place 1703 revealed the patient had a " a current resident of SBC Charlotte. All staff are being inserviced on their ability to 3/31/18 contact and utilize the police department if a patient addtional Further review of the medical record revealed event escalates to one that cannot be otherwise there was no evidence available to determine models of handled by the staff on duty. In order to remain on facility staff implemented a treatment plan to the schedule, staff not in attendance for the care in address the history of elopement. Review of inservice are required to receive training on this place facility video recordings on 01/10/2018 of requirement prior to any scheduled work by the residential hallways on 01/1/2018, revealed completion date. Resident #12, fully dressed in The new CEO is now conducting rounds on each nursing unit. Evening and weekend shifts are being Review of admission orders revealed the resident covered by the Administrator on Call. The questions that are standardly being asked include the following was placed on every 15 minute observations and that are adapted from the Studer model: remained on every 15 minute observation on (1)Do you have the right tools that you need to do 01/01/2018. Review of an Observation Sheet your job today effectively? If not, what is needed? dated 01/01/2018 revealed the resident was (2)Do you have the right amount of people to do assigned to Room on 01/01/2018. Review of your job effectively? If not, describe. an Observation Sheet dated 01/01/2018 revealed every 15 minute checks were documented from

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0000 through 2345. Review revealed the resident

PRINTED: 02/07/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) (3) Is there anyone that you want to recognize today V 512 V 512 Continued From page 128 as a team member that has been especially helpful to you? If so, who? was located at " (4) Are you feeling safe on your unit? If not, why? from ; then ' from (5) Is there any way that we can further support you? ; then ' " from ; then Three evidence-based programs have been from identified to assist staff in gaining more effective Review of Night shift notes recorded by MHT #16 skills in working with patients in the PRTF revealed ' environment. One is known as the Collaborative Problem Solving® (CPS) model. The tool has been highly successful in reducing aggressive patient behaviors as well as eliminating the need for restraint and seclusion in multiple acute hospital settings (http://www.thinkkids.org/learn/our-..." Review of the medical record on 01/10/2018 collaborative-problem-solving-approach/). The revealed no documentation of a nursing second tool is from Advanced Trauma Solutions assessment in the record. (advanced trauma.com). The last tool is the CARE program model that is supported by UNC Charlotte Interview on 01/12/2018 at 0955 with RN #5 and Duke. All programs utilize a trauma-informed revealed each resident had a daily observation care approach but do not use a level system. sheet and the MHT assigned to the resident is responsible for doing the 15 minute observation b) Date of completion: Implementation of new checks. Interview revealed the 15 minute checks patient care model 03/31/2018 means "eyes on the resident and they know exactly where the resident is, document location Implementation of rounding using Studer Model and initial." RN #5 stated that the residents that tool: 02/16/2018 eloped on 01/01/2018 started coming back one at a time around 0000. The nurse stated it took c) Responsible person: around 30 to 40 minutes to get them all back. RN Chief Executive Officer #5 reviewed observation sheets for Resident #12

Resident #9 revealed a

she documented that. It isn't correct."

admitted to the PRTF unit on

2017 due to

6. Open medical review on 01/11/2018 of

0000. "She couldn't have laid eyes on the

and stated it was not accurate. The nurse stated

at 2300, but didn't return until

it was documented that the resident was in the

resident. wasn't back yet. I don't know why

d)Monitoring procedure to ensure correction

Staff's perceptions about feeling "ill equipped" to

handle the number and acuity of patients is being

As part of the daily rounds made by the CEO, staff

(1) Do you have the right tools that you need to do your job today effectively? If not, what is needed?

(2) Do you have the right amount of people to do

your job effectively? If not, describe.

will be asked to answer the following questions:

monitored as follows:

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STATE FORM V3NZ11 If continuation sheet 129 of 164 Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) (3) Is there anyone that you want to recognize today V 512 V 512 Continued From page 129 as a team member that has been especially helpful to you? If so, who? . Review of the (4) Are you feeling safe on your unit? If not, why? Intake Assessment dated /2017 revealed (5) is there any way that we can further support you? Resident #9 was at risk for elopement with a ." Review revealed history of ' These rounds will occur daily (weekends covered by Resident #9 was not placed on elopement AOC). The findings of this review will be reported at precautions on admission. the Morning Meeting of Hospital Leadership Staff, Monday through Friday. Further review of the medical record revealed These findings will be aggregated and presented on a there was no evidence available to determine weekly basis to the newly formed SBC, Charlotte facility staff implemented a treatment plan to PRTF PI Committee. A Governing Board member address the history of elopement. Review of shall be an attendee of that meeting to hear the facility video recordings on 01/10/2018 of results and actions. The findings, conclusions, residential hallways on 01/1/2018 revealed recommendations, and actions taken will be Resident #2, fully dressed forwarded by the Director of Quality/Compliance/ Risk to the Hospital's monthly Quality/PI Council, Review revealed Resident #9 lived on the 200 Medical Executive Committee and Governing Board hall. Review of a nursing note dated 01/01/2018 at each of their respective meetings. at 2120 revealed Resident #9 ' 1/5/18 Root cause (contributing factor): 12) Perception of staff of being "short staffed" on staffing some shifts assessed as . Review of an Observation Sheet dated part of RCA 01/01/2018 revealed every 15 minute checks a) The criteria for admission has been revised to were documented from 0000 through 2345. exclude patients with a history of felonious behavior, Review of the Q 15 Minute Observation sheet 2/16/18 history of elopement from a facility, history of gang dated 01/01/2018 revealed Resident #9's location involvement, history of substance abuse disorder, Revised from 1800 to 2345 was 1 and history of a conflict or affiliate relationship with rounds in ." Review revealed a nursing a current resident of SBC Charlotte. place note documented by RN #5 dated 01/02/2018 at 0010 that recorded " The new CEO for SBC, Charlotte is now making rounds on each nursing unit. Evening and weekend shifts are being covered by the Administrator on Call. One of the questions that is standardly being asked includes the following that is adapted from the Studer model and that is specific to staffing: "Do you have the right amount of people to do your job effectively? If not, describe". Real time assessment of staff's perceptions and interventions,

Division of Health Service Regulation

". Review of a physician order dated

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETE	ΞD
		MHL0601258	B. WING		01/17/2	2018
NAME OF F	PROVIDER OR SUPPLIER	STREETAL	DRESS, CITY, S	TATE, ZIP CODE		
		1715 SHA	RON ROAD W	VEST		
STRATE	GIC BEHAVIORAL CENTE	R-CHARLOTTE CHARLO	TTE, NC 2821	0		
(X4) ID	SUMMARYST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	v	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE
V 512	01/02/2018 revealed elopement precautio Progress note dated Resident #9 was par unit. Further review on note revealed Resident #9 stated "Resident #9 stated"  Review on 01/11/201 Review Report dated	Resident #9 was placed on n. Review of the Physician 01/04/2018 revealed to fit the elopement on the of the physician progress ent #9 reported "Review revealed"."  "Review revealed"."  18 of a Health Incident to 10/02/2018 revealed from the unit on 01/01/2018 700 by	V 512	as appropriate to reduce their discomfort employed. Examples include calling in a P member or reallocating staff to the area w is a perception of "short staffing".  A daily review of staffing coverage for all s now being reported to the Hospital's Morr Meeting of Leadership staff. Shifts out of with staffing are addressed through PRN c leadership assisting with any deficits in sar Whenever there is a patient event requiring cause analysis, the adequacy of staffing and competencies and qualifications of staff at to determine if staffing might have been a the occurrence or prevention of same.  (b) Date of implementation of all elements.	RN staff where there hifts is ning compliance overage or me. ng a root nd re assessed factor in	
	peers.  7. Open medical reconstruction Resident #10 reveals admitted to the Psycifacility (PRTF) from [2017] with a diagram of the intake assessing was currently [2017].	along with other  cord review on 01/10/2018 for ed a hiatric Residential Treatment  agnosis of eview of the nursing notes 10 arrived on the PRTF unit nursing notes revealed the with no r discomfort. Review of the ed the resident had old		Rounds by CEO using Studer model: 02/1 Daily review of staffing coverage and inclustaffing as a part of RCA discussion: 01/05  (c) Responsible person: Director of Nursing  (d)Monitoring procedure to ensure constant of the daily rounds made by the Constant of people of the daily rounds made by the Constant of people of the daily rounds made by the Constant of people of the daily rounds made by the Constant of people of the daily rounds made by the Constant of people of the daily rounds made by the Constant of people of the daily rounds made by the Constant of the d	orrection  fed are  EO, staff stions: to do your  d  reporting for all vities are	

1		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL0601258	B. WING		01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE	
			RON ROAD W	EST	
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE CHARLOT	TE, NC 28210	)	
(VA) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 512	Further review of the Assessment Form" d Resident #10 had the violence: "  the medical record re available to determin treatment plan to addelopement and patte facility video recording residential hallways of Resident #10, fully downward documented by RN # that recorded "  revealed a note documented by RN # that recorded "  "Review of the record documented by RN # that recorded "  "Review of the record documented by RN # that recorded "  "Review of the record documented by RN # that recorded "	"Admission Intake ated //2017 stated e following risk and history of" Based on eview there was no evidence e facility staff implemented a dress the history of rns of violence. Review of revealed ressed in	V 512	The findings of compliance with staffing gr staff's perceptions about staffing are being aggregated and presented on a weekly basis to the newly formed SBC, Chapart PI Committee. A Governing Board m shall be an attendee of that meeting to he results and actions. The findings, conclusion recommendations, and actions taken are beforwarded by the Director of Quality/Com Risk to the Hospital's monthly Quality/PI CM Medical Executive Committee and Govern at each of their respective meetings. In active above, The findings from all Root Cause where staffing number is felt to have been are being presented to the Governing Boa of their respective meetings.  Root cause (contributing factor):  13) S&R policy and procedure not confollowed per requirements)  All nursing staff with responsibility for or restraint requirements are being apthrough inservice activity of the requispecific to the associated policy and procedure for Seclusion Restraint has been reviewed with the Staff to ensure their compliance with associated requirements.	arlotte leember lear the lons, being pliance/ Council, ling Board ddition to se analyses in a factor rd at each  assistently 2/18/18  r seclusion loprised rements lorocedure. staff not quired to lorior to lorior to lorior to lorior date.  an and lorements lorocedure.  staff not lorior to lorior to lorior to lorior to lorior to lorior date.
	assigned to Room of the Observation S	on 01/01/2018. Review heet dated 01/01/2018 inute checks were recorded		b) Date of completion: 02/18/2018	
	1	345. Review revealed the		c) Responsible person:	
	resident was located			Director of Quality/Compliance/Ri	sk

Division of	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	COMPLETED			
		MHL0601258	B. WING		04/4	7/2040
		MITEOGO 1238			U1/1	7/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	ZIP CODE		
		1715 SH	ARON ROAD WEST	-		
STRATEG	GIC BEHAVIORAL CENTE	R-CHARLOTTE CHARLO	OTTE, NC 28210			
0/10/15	CLIMANAADVCT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	CORRECTION (EACH CORRECTIV	/E	(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)		ACTION SHOULD BE		DATE
				CROSS-REFERENCED TO THE		
\/ 512	Continued From page	132	V 512	d) Monitoring procedure to ensure co	orrection	
V 312	Continued From page	5 132	V 312			
				100% of episodes of Seclusion and Re	straint	
		. Review of the		will be monitored for compliance with	1	
	Observation Sheet da	ated 01/02/2018 revealed	A Laboratoria de Companyo de C	requirements in accordance with the p	policy and	
	every 15 minute chec	cks were recorded from 0000		procedure.		
	through 2345. Revie	w revealed the resident was				
	located at '			The summary of findings by the Direct		
*		hift notes recorded by MHT		Quality/Compliance/Risk will be repor		
	#16 revealed the resi	dent "		Morning meeting of Hospital Leadersh	nip staff	
				on a Monday through Friday basis.		
				These findings will be aggregated and		
				presented on a		
				weekly basis to the newly formed SBC Charlotte PRTF PI Committee. A Gove		
		Review of the medical		Board member shall be an attendee o	- 1	
	record on 01/10/2018	revealed no documentation		meeting to hear the results and action		
	_	ent in the record. Review of		findings, conclusions, recommendatio		
		018 revealed a nursing note		actions taken will be forwarded by the		
		5 dated 01/02/2018 at 0010		of Quality/Compliance/ Risk to the Ho	i	
	that recorded	<u> </u>		monthly Quality/PI Council, Medical E		
	. Note recor	ded the resident was "		Committee and Governing Board at ea	ach of	
		." Note recorded that		their respective meetings.		
	Property and the second					
				Root cause (contributing factor):		2/14/18
				14) Doors to Hallways were being	5	2/14/10
				propped open by staff at night, t	hereby	
				allowing potential for unauthorize	ed access	Follow up
				to other patient hallways and inc		
		ephone orders dated		risk of patients intermixing		
		revealed orders to place				2/18/18
	Resident #10 on	for		inappropriately.		Specific
	and upon return to facility	and Review of a Coope	1000			
		cumented by the Director of		a) All hospital staff with patient ca		policy
		S), dated 01/02/2018 and	b opening and a	physical interaction are being inst		review
	1	r" on 01/03/2018 not timed		that the doors between units are r	not to be	with all
		h the client, the Director of	abuning several as	propped open.		staff.
		n the client, the Director of ne Milieu Manager (MM)				
		s returned to the facility		A policy and procedure has been		
	and the resident was	. Note recorded the DCS		developed to address this require	ment.	
	and the DON question	ned client about any injuries,		Attachment "K" delineates the po		
		is. Note recorded the DCS		its associated requirements.	•	
	pain or other concern	is. Hole recorded life DOS		7		

STATE FORM

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		D.	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL0601258	B. WII	NG		01/1	7/2018	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, C	CITY, STA	TE, ZIP CODE			
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	1715 SHARON RO		ST			
			CHARLOTTE, NC	28210				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL .SC IDENTIFYING INFORMATIO	L PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE	
V 512	Review of a Health In Resident #10 comple 01/01/2018 recorded  8. Open medical recorded a PRTF on 10/26/2017  Psychosocial Assess social worker on patient stated, "Review of admission was placed on every remained on every 101/01/2018.  Review of an Observ 01/01/2018 revealed	esident's return to the urent was assessed by a N). Review of the note dated 01/04/2018 a cident Review Report for ted by RN #1 and dated the with admitted to the with eview of a Comprehens ment Tool completed by [/2017 at 1000 revealed to minute observation on the complete dated the resident was assign at the resident was assign at the resident was assign.	and 588 exive a dithe identiand		A follow-up memorandum is being p and distributed to all staff to alert th they are not to leave the doors open units as this compromises the securit units as well as failure to follow polic to disciplinary action up to and include termination.  b) Date of completion: 02/18/2018  c) Responsible person: Director of EOC  d) Monitoring procedure to ensure of Compliance with this requirement where accomplished by daily random checks shift and for each patient care area who coupied patients by the Safety Office camera and direct view means. The from this review will be reported on through Friday basis at the Morning S, and Sunday results will be incorporated monday's report). The findings, con and actions will be forwarded to the PRTF PI meeting, of which a Governimember is in attendance, the Quality/Performance Improvement and the Governing Board at each of respective meetings.	correction ill be s on each with ter per findings a Monday meeting (F, rated into clusions, Hospital's ng Board Council,		
	Room on 01/01	_						

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 512 Continued From page 134 V 512 every 15 minute checks were documented from 0000 through 2345. Review revealed the resident was located at " ; then " " at from then " from ; then ' then ' from ; then " . Review of Night shift notes recorded by MHT #13 revealed ' Review of nursing notes documented by RN #1 dated 01/01/2018 at 2030 revealed the resident was involved in and Review of notes at 2202 revealed ." A nursing note by RN #1 on 01/02/2018 at 0000 recorded ." Review of the medical record on 01/10/2018 revealed no documentation of a nursing assessment in the record. Review on 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded "

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:				
		MHL0601258	B. WING		01/17/2018		
NAME OF PRO	VIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE			
		1715 SHA	ARON ROAD WES	т			
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE  CHARLOTTE, NC 28210							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROS <b>S</b> -REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE		
V 512 C	evealed " Review of a Health In Resident #8 dated 01  Closed medical recult/09/2018 revealed dmitted to the PRTF  evealed the admission in the company of th	"  cord review of Patient #3 on a Review of a nursing note need at 1031 revealed a blank Review of a restrictive /2018 from 2002 to 2008 8 was 108 because 105 at 1054	V 512	DEFICIENCY)			

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ B. WING\_ MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 512 V 512 Continued From page 136 ..." Review of the Observation Sheet dated 01/01/2018 revealed from 1800-2345 Resident #3 was ' ." Review of the MHT note on 01/01/2018 revealed " Review of a telephone physician order dated 01/02/2018 not timed revealed " Review of the medical record on 01/09/2018 revealed no documentation of a nursing assessment on 01/01/2018 in the record. Review on 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at 0015 that recorded the resident returned to the facility . Notes recorded revealed Resident #3 was ' Review of a "Therapy Services Note" written on 01/03/2018 at 1132 revealed " 10. Closed medical record review on 01/09/2018 of Resident #6 revealed a

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admitted to the PRTF on

/2017 due to

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resident '

resident on

and

." Review of physician order dated

and

upon

01/02/2018 revealed an order to place the

return. Review of a nursing note documented by RN #1 dated 01/01/2018 at 2202 revealed

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL0601258	B. WING		01	17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	IARON ROAD WEST OTTE, NC 28210	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 512	Continued From page	: 138	V 512			
	o1/02/2018 at 0000 re facility accompanied injuries and was place precautions.  In summary, facility s resident's patterns of residents and history of ten residents to car	taff failed to communicate elopement for seven of ten of violent behaviors for ten re staff, failed to implement				
	policies and elopement precautions thereby creating an unsafe environment for the delivery of safe resident care. As a result, residents destroyed wooden furniture and made weapons which placed residents and staff in an unsafe environment. Subsequently, ten residents eloped from the facility.					
	for Resident #1 reveal admitted to the Psych Facility (PRTF) on intake assessment resident review revealed Resident review revealed Resident facility on 01/01/2018 Admission vital signs	Review of the evealed the resident had a Further review ment revealed documentation elopement risk related to the Record dent #1 had a known history ission and eloped from the Review of Lation documented on				

STATE FORM

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: \_ B. WING \_ MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 512 | Continued From page 139 V 512 " Review of the medical record revealed documentation of a Resident #1 on 01/02/2017 from 1321-1342 for Review of the Medication Administration Record revealed documentation of administered on 01/05/2018 no time. Review of the Restrictive Intervention documentation dated 01/05/2018 at 2015 revealed a physician order for for . Resident #1 was . Resident and #1 was . Restrictive intervention documentation revealed Resident #1 was placed in a 01/05/2018 at 2015 and released at 2040. Restrictive Intervention documentation revealed Resident #1 was administered at 2025. Review of the medical record revealed a nursing note documented by RN #5 on 01/05/2018 at 2040 that recorded " ." Review of the medical record revealed documentation of a

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Resident #1 on 01/05/2018 from 2015-2040 for

PRINTED: 02/07/2018 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING 01/17/2018 MHL0601258 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) ∨ 512 Continued From page 140 V 512 Review of a nursing note documented by RN #5 at 2130 revealed " ." Review of nursing note documented by RN #5 revealed ' " Review of restrictive intervention documentation revealed Resident #1 was 01/05/2018 at 2224 after Resident #1 was . Documentation revealed Resident #1 was on 01/05/2018 at 2323. Review of an Observation Sheet dated 01/05/2018 revealed the resident was assigned to Room on 01/05/2018. Review of the Observation Sheet

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located at '

dated 01/05/2018 revealed every 15 minute checks were recorded from 0000 through 2030 and 2245 through 2345. Review of observation sheet revealed no available documentation of Resident #1's location on 01/05/2018 from 2045 through 2230. Review revealed the resident was

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 512 Continued From page 141 ." Review of the night shift notes dated 01/05/2018 recorded by MHT #11 revealed " ." Review of physician orders revealed a telephone order dated 01/05/2018 at 2224 for ." Review of the medical record revealed documentation of a Resident #1 on 01/05/2018 from 2224-2323 for Review of orders revealed a telephone order dated 01/06/2018 at 2224 " of the medical record revealed no available documentation of an observation sheet on 01/06/2018. Review of physician orders revealed a telephone order dated 01/07/2018 at 2224 Review of the Observation Sheet dated 01/07/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review of physician orders revealed a telephone order

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dated 01/08/2018 at 1335 "

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING \_ MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (FACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 512 V 512 Continued From page 142 Review of the Observation Sheet dated 01/08/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review of a Health Incident Review Report completed by RN #5 and dated 01/05/2018 recorded " Review of the report revealed the date and time of the incident was 01/05/2018 at 2015. Review of a Health Incident Review Report completed by RN #1 and dated 01/05/2018 recorded " ." Review of the report revealed the date and time of the incident was 01/05/2018 at 2130. Review of a Health Incident Review Report completed by RN #5 and dated 01/05/2018 recorded ' ." Review of the report revealed

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the date and time of the incident was 01/05/2018

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V3NZ11

. The resident was Review of a

> " Review of /2017 revealed the

Comprehensive Psychosocial Assessment Tool

every 15 minute observation checks. Review of a

nursing note documented by RN #5 on 01/05/2018 at 2030 revealed the resident

documented by a

admission orders dated resident was placed on

> because Notes recorded

(not timed) recorded the resident

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING \_ MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 512 Continued From page 144 V 512 Review revealed an order was received for the medication was not administered because the Review of the emergency restrictive intervention revealed the resident remained from 2015 through 2040. Nursing notes recorded by RN #5 on 01/05/2018 at 2130 recorded Notes recorded the resident Notes revealed the legal guardian was notified. Review of physician's orders revealed a telephone order dated 01/05/2018 (not timed) to Review of an Observation Sheet dated 01/05/2018 the resident was in and 1545. Review revealed from 1600 through 2345 the resident's location was left blank. Review of a Health Incident Review Report for Resident #2 dated 01/05/2018 at 2030 revealed 3. Open medical record review of Resident #8 revealed a admitted to the PRTF on /2017 with Review of a Comprehensive Psychosocial Assessment Tool completed by a /2017 at 1000 revealed the on patient stated, " Record review revealed Resident #8 had a known history of elopement on admission and eloped

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from the facility on 01/01/2018. Review of

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601258	B. WING		01/1	7/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	RON ROAD WE TE, NC 28210	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 512	admission orders reversible admission orders reversible and every 15 m of nursing notes docu 01/05/2018 at 2200 research at 2	ealed the resident was inutes observation. Review imented by RN #5 dated evealed  accident Review Report for /05/2018 at 2030 revealed  cord review of Resident #3 led a	V 512			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SUR		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
		MHL0601258	B. WING		01/17/2	2018	
NAME OF B	DOVIDED OD CURRI IER	CTDEET AP	DRESS, CITY, STATE	ZIR CODE			
NAME OF P	ROVIDER OR SUPPLIER						
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	RON ROAD WES	••			
			TTE, NC 28210				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETE DATE	
				DEFICIENCY)			
V 512	Continued From page		V 512				
	nursing note dated 0.	" Review of a 1/05/2018 at 2330 revealed "					
		770072010 412000 10104104					
	"De is of some						
	" Review of a nursii 01/05/2018 at 2200 r						
	01/03/2010 at 22001	evealed					
		" Review of physician					
	orders dated 01/05/2						
		" Review of a					
	nursing note dated 0	1/06/2018 at 0130 revealed					
					100000000000000000000000000000000000000		
		" Review revealed					
	I .	charged to local police					
	custody and did not r	eturn to the facility.					
	Review of a Health In	ncident Review Report dated					
	01/05/2018 at 2030 r						
		."					
	5 Paviou on 01/11/	2018 of the medical record of					
	Resident #9 revealed						
		17 to the facility due to					
		Review of the					
	Intake Assessment d						
	Resident #9 was at r	isk for elopement with a					

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING \_ MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 512 V 512 Continued From page 147 ." Record review revealed history of " Resident #9 had a known history of elopement on admission and eloped from the facility on 01/01/2018. Review revealed Resident #9 was not placed on elopement precaution on admission. Review of the Nursing Shift Note dated 12/31/2017 revealed Resident #9 had Review revealed Resident #9 lived on the hall. Review of a physician order dated 01/02/2018 revealed Resident #9 was placed on . Review of a nursing shift note dated 01/05/2018 at 2200 revealed Resident #9 was Resident #9 was Resident #9 was Review on 01/11/2018 of the Health Incident Review Report dated 01/05/2018 revealed Resident #9 Additional review revealed Resident #9 was 6. Open medical record review on 01/10/2018 for Resident #10 revealed a admitted to the Psychiatric Residential Treatment Facility (PRTF) /2017 with a diagnosis of Record review revealed Resident #10 had a known history of elopement on admission and eloped from the facility on 01/01/2018. Review of the nursing notes

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resident was

revealed Resident #10 arrived on the PRTF unit at 2030. Review of nursing notes revealed the

, with no

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING MHL0601258 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 512 V 512 | Continued From page 148 complaints of pain or discomfort. Review of the nursing notes revealed the resident had old injuries noted to Admission vital signs were of the intake assessment revealed the resident was currently . Further review of the intake assessment revealed documentation of elopement risk related to the resident . Review of nursing notes dated 01/05/2018 at 2200 revealed Resident #10 ." Review of telephone order dated 01/05/2018 not timed revealed an order to ." Review of a 7pm-7am nursing shift note dated 01/06/2018 at 0130 revealed ' f." Review of an Observation Sheet dated 01/05/2018 revealed the resident was assigned to Room on 01/05/2018. Review of the Observation Sheet dated 01/05/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at 1 Review of the night shift notes recorded by MHT #16 revealed the resident Review of an Observation Sheet dated 01/06/2018, 01/07/2018 and 01/08/2018 revealed the resident was assigned to Room

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01/06/2018, 01/07/2018 and 01/08/2018. Review

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Division of Health Service Regulation

PRINTED: 02/07/2018

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 512 | Continued From page 150 V 512 Review on 01/16/2018 at 1435 of the 100, 200, and 300 hall video monitor recordings for 01/05/2018 revealed: Residents wearing bandanas, double layers of clothing and / or jackets between 2010 through 2107. 2010: Residen were on the 100 hall at the 100/200 hall door. MHT #11, #12, #16, #18, and #26 in the 100 hall with MM#8 and LPN #6. 2014: MM#8, LPN #6 and RN #27 escorted ) from the 100 hall Resident ( back to the 200 hall. The 100 to 200 hall door was opened and Resident charged the door. MHT #18 and #26 prevented Resident from entering the 200 hall. 2015: RN #27 opened the 200/100 hall door and Resident charged the door and entered the 200 hall. MHT #12, #16, and #26 entered the 200 hall with the residents. were escorted back 2016: Resident from the 200 hall back to the 100 hall. 2020: Resident was in a manual hold by MHT #18 on 200 hall. Resident was pacing the 200 hall and kicking the 200 hall doors. MM #8 was walking around with Resident 2024: Resident had broken DVDs and were attempting to cut their arms with broken DVDs on the 100 hall. MHT #26 took the broken DVD's away from them.

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hall back to the 100 hall

2029: Resident was escorted from the 200

2032: Resident was placed in a manual hold by MM#8 on 200 hall. RN #1 was observing the

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 01/17/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOTTE CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 151 V 512 hold. Resident was escorted back to the 100 hall from the 200 hall by MHT #16 and #17. 2032: Resident came into the hall way from the 100 hall dayroom with a wooden board. 2033: MHT #26 took the wooden board from Resident #10. 2033: MHT #16 entered the 200 hall and Resident charged the door to the 200 hall and entered the 200 hall from the 100 hall. 2034: MHT #18 released Resident from a hold in the 200 hallway. 2035: Resident walked towards MM#8 who was manually holding Resident on the 200 hall. MHT #18 placed Resident in a hold. LPN #6 entered the 200 hall from the 100 hall and Resident charged the door and entered 200 hall. 2035: Resident escorted from 200 hall back to the 100 hall by LPN #6. Resident kicked MHT#18 who was holding Resident 2036: Resident was released from a manual hold on the 200 hall. 2037: Resident walked who was being manually held toward Resident by MM#8 on the 200 hall. 2039: Resident was in the 100 hall dayroom and pulled a wooden board from a chair and went into the 100 hallway. LPN #6 escorted Resident from the 200 hall back to the 100 hall. 2040: MHT #11 took the wooden board from Resident and placed it in the bin closet on the 100 hall. MHT #16 escorted Resident # the 200 hall back to the 100 hall. 2041: Resident kicked the window in the 100 hall dayroom multiple times. 2042: Resident entered the 100 hall dayroom

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with a wooden board and was hitting the window with the board. Resident was given the

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
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V 512	Continued From page	e 152	V 512		
	wooden board by Re window. Review reveat this time. 2043: Resident had ayroom and was chawith the chair. 2045: Resident had attempting to cut his attempting to cut his attention attempting to cut his attention Resident 2047: Resident second a wooden lentered the 100 hall. 2049: A piece of wood from Resident by bin room. 2053: Three emerger personnel arrived on 100 hall. 2054: Resident wahold. 2055: Six police office and went to the 100 hall. 2058: Five additional 200 hall by AS #22. (EMS personnel) 2101: Resident endoor was opened by through. Resident the 100 hall when doenter. 2106: Resident hid down and arrested by 2107: Resident the 107: Resident second hall when doenter.	and also hit the ealed no staff were present and a chair from the 100 hall arging the 100/200 hall door and a DVD and was arm with the broken DVD in MHT #17 took DVD away corted back to 100 hall from hall dayroom Resident got board from the chair and den board was removed MHT #26 and locked in the acceptable from a manual ers arrived on the 200 hall hall. police officers brought to the Total 11 police officers and 3 aftered the 300 hall when the LPN #6 to let medics entered the 200 hall from or was opened for police to			
	Telephone interview	on 01/09/2018 at 1015 with			

RN #3 revealed a second incident occurred on

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things were getting out of control, feel like we are about to have a riot. RN #5 came in. I was not on the 300/100 hall. Name (Resident ) became aggressive towards the police and was arrested. Took Name (Resident ) out but brought back in. Took Name (Resident assaulted someone else not sure if it was a staff member." Interview revealed when RN #1 was asked if she was scared during the 01/05/2018 incident she said

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MM#8 was called out of shift report to the 100 hall at about 1930. Interview revealed when he arrived to the 100 hall residents on the 100 hall were crowded around the 100/200 hall door and staff were attempting to move them away from

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200 hall. Interview revealed LPN #6 did not know why Resident was on the 100 hall instead of the 200 hall. Interview revealed "I would have never put (Resident and (Resident on the same hall." Interview revealed when LPN #6 opened the door to the 200 hall Resident and multiple other residents from the 100 hall charged

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PRETIX 1AG REGULATORY ORLS DENTIFYING INFORMATION)  V 512  V 512  Continued From page 156  the door and entered the 200 hall. Resident was put in a manual hold on the 200 hall. Interview revealed Resident in a manual hold on the 200 hall pacing and kicking doors. Interview revealed "there was not enough staff to put (Resident in an annual hold) in the residents wanted to elope again, "we were on high alert, we just didn't know when it was going to happen." Interview revealed LPN #6 and other staff knew the residents wanted to elope again, "we were on high alert, we just didn't know when it was going to happen." Interview revealed Resident interview revealed after multiple residents had oome from the 100 hall to the 200 hall LPN #6 called RN #5 and told her "we needed help amd more staff, she notified other administrators." Interview revealed LPN #8 called a Code Black (code riot) multiple times on staff radios and overhead. Interview revealed the police at 2044. LPN #5 stafed "the nurse's role during a riot is to take charge and try to get the unit under control. I stationed people at different places in the building." Interview revealed RN #1, the nurse scheduled on the 100, 200, and 300 unit was at the nurse's station during the incident. Interview revealed residents also pulled out wooden boards and staff members were hurt including LPN #6. [Interview revealed RN #1 was supposed to give Resident in an injection "she (RN #1) got nervous and dropped the injection, so we wasted it." Interview revealed RN #6 ereidents also pulled out wooden boards and staff members were hurt including LPN #6. [Interview revealed RN #5 came from home to the facility at about 2000. Interview revealed the incident on 01/05/2018 lasted about an hour. Interview	(VA) ID	SLIMMARY STA		<del></del>	PROVIDER'S PLAN OF CORRECTIO	N OF
the door and entered the 200 hall. Resident was put in a manual hold on the 200 hall. Interview revealed Resident was on the 200 hall pacing and kicking doors. Interview revealed "there was not enough staff to put (Resident and (Resident) in a manual hold." Interview revealed residents had been "ranting and raving" about eloping after the 0/10/12018 incident. Interview revealed LPN #6 and other staff knew the residents wanted to elope again, "we were on high alert, we just didn't know when it was going to happen." Interview revealed and 10/55/2018 day shift there were extra staff present. Interview revealed after multiple residents had come from the 100 hall to the 200 hall LPN #6 called RN #5 and told her "we needed help and more staff, she notified other administrators." Interview revealed LPN #6 called a Code Black (code riot) multiple times on staff radios and overhead. Interview revealed RN #5 came to the facility and AS #23 called the police at 2044. LPN #6 stated 'the nurse's role during a riot is to take charge and try to get the unit under control, I stationed people at different places in the building." Interview revealed RN #1, the nurse scheduled on the 100, 200, and 300 unit was at the nurse's station during the incident. Interview revealed RN #1 was supposed to give Residents also pulled out wooden boards and staff members were hurt including LPN #6. Interview revealed residents also pulled out wooden boards and staff members were hurt including LPN #6. Interview revealed RN #5 came from home to the facility at about 2000. Interview revealed the staffing that night met the "correct numbers" but there was not enough staff to keep the residents and staff safe. Interview revealed RN #5 came from home to the facility at about 2000. Interview revealed the incident on 01/105/2018 lasted about a hour. Interview	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE COMPLETE
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	V 512	the door and entered was put in a manual halterview revealed Rehall pacing and kickin "there was not enoug and (Resident in a revealed residents has about eloping after the Interview revealed LP the residents wanted high alert, we just did to happen." Interview day shift there were erevealed after multiple the 100 hall to the 200 and told her "we need notified other adminis LPN #6 called a Code times on staff radios are vealed RN #5 came called the police at 200 nurse's role during a revealed RN #1, the revealed RN #1, the revealed RN #1, the revealed RN #1) got nervinjection, so we waste residents also pulled members were hurt in revealed the staffing the numbers" but there we the residents and staff RN #5 came from hor	the 200 hall. Resident hold on the 200 hall. esiden was on the 200 g doors. Interview revealed h staff to put (Resident a manual hold." Interview to be en "ranting and raving" to 01/01/2018 incident. Which and other staff knew to elope again, "we were on in the know when it was going to revealed on 01/05/2018 extra staff present. Interview to eresidents had come from 0 hall LPN #6 called RN #5 ded help and more staff, she intrators." Interview revealed to Black (code riot) multiple and overhead. Interview to the facility and AS #23 load. LPN #6 stated "the riot is to take charge and try control, I stationed people at the building." Interview hurse scheduled on the 100, as at the nurse's station interview revealed RN #1 to Resident an injection rous and dropped the end it." Interview revealed out wooden boards and staff including LPN #6. Interview that night met the "correct ras not enough staff to keep ff safe. Interview revealed met to the facility at about	V 512		
revealed "once the police came and residents realized they were outnumbered, they calmed		revealed "once the po	olice came and residents			

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arrived shortly after that. Interview revealed this incident could have been prevented if Resident and Resident were not put on the same hall

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V 512	together. Interview reknow why Resident #26 stated "I did not Interview revealed the keep residents and so Interview on 01/17/20 revealed she was so 0730 on 01/05/2018. #28 was scheduled arrived to work she where the 200 hall revealed around 193 radioed to MHT #28 100 hall to program for revealed MHT #28 b 100 hall and then we recreation room. Interesident was going to than where they lived report. Interview reveremember if Resider 100 hall was discuss what I am told, (MM# to the 100 hall, so Interview on 01/17/2 MHT #12 (Mental He was also working the Interview revealed "to elope. Name (reside Interview revealed the hall had plan to elopteriew revealed so Interview reveale	evealed MHT #26 did not was on the 100 hall. MHT feel safe that night." ere was not enough staff to taff safe that night.  018 at 1215 with MHT #28 heduled to work 1900 to Interview revealed MHT on the 200 hall and when she went to the recreation room esidents were. Interview 0 on 01/05/2018 MM#8 to bring Resident to the for one hour. Interview rought Resident to the erview revealed MHT #28 did to Black called overhead rview revealed usually if a to program on a different hall did it was discussed in shift ealed MHT #28 did not the programming on the ted. Interview revealed "I do the black down to bring (Resident to I did."  018 from 1435-1450 with ealth Technician) revealed he exp-7a shift on 01/05/2018. the residents decided to interview revealed "kids on the staff tried to keep the Interview revealed "kids on	V 512		

revealed the residents should not have bandanas in their rooms as they are associated with gangs.

STATEMEN	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	PLETED
				,		
		MHL0601258	B. WING		01	/17/2018
NAME OF D	DOMBED OD CHEDITED	I	DDDECC CITY CTA	TE ZID CODE		1172010
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT ARON ROAD WE			
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	TTE, NC 28210	31		
240.15	CLIMANADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	NE CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETE DATE
V <b>51</b> 2	Continued From page	e 159	V 512			
	Interview revealed the	· · · · · · · · · · · · · · · · · · ·				
		checked every night while				
	1	eeping. The room checks				
	should be documented	ed on the hygiene check				
	sheets.					
	Interview on 01/11/20	)18 at 1645 with MHT #14				
	revealed she was in t	he recreation room with the				
	200 hall on 01/05/201	18 at 1930 with MHT #15				
	and MHT #28. Intervi	ew revealed she didn't				
	believe all the 200 ha	II residents were in the				
	recreation room. Inte	erview revealed MHT #28				
	escorted Resident	and Resident back				
		all to use the bathroom.				
		e and MHT #15 never				
		transition the 200 hall back				
	to the unit and remain	ned in the recreation room				
	from 1930-2300. Inte	erview revealed she saw				
	8-10 police officers co	ome downstairs with AS #22				
	and walked towards t					
		e 200 hall residents were				
	given their medication	ns and returned to their				
	rooms.					
	1.1	040 for a 4045 4400 with	the structure of the st			
		018 from 1315-1430 with				
		e incident on 01/05/2018				
		hall. Interview revealed				
		ident were supposed to	N-1000			
	l '	HT #28 was told Resident				
		the 100 hall, so she walked	THE PROPERTY OF THE PROPERTY O			
		om the rec room. Resident				
	<del></del>	nterview revealed the				
	residents on the hall					
		s. Interview revealed the				
		dent tell Resident bout				
		lent was removed from				
		erview revealed the staff				
		hat "bout to be a show"				
		planning to elope." MM #8				
	passed through the h	allway, Interview revealed				

Division of Health Service Regulation

Division	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION		JRVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	IED
		MUL 0004.259	B. WING		04/4	7/2048
		MHL0601258			01/1	7/2018
NAME OF P	ROVIDER OR SUPPLIER	STREETAL	DRESS, CITY, STATE	E, ZIP CODE		
		1715 SHA	RON ROAD WES	т		
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE CHARLO	TTE, NC 28210			
	CUMMADVET			PROVIDER'S PLAN OF CORRECTION	J	WE) .
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	i	(X5) COMPLETE
TAG	(	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
V 512	Cantinuad From page	160	V 512			
V 512	Continued From page	2 160	V 312			
	"Once out of room MI	M #8 told Resident to go				
		n. Once Residen back on				
		ed to push me to get the				
		ran through everybody.				
		ent trip into room 207.				
		on Resident Resident				
		T #12 and Rec Therapist				
		oorway. Resident stating				
		r, you need to let him go.'				
		tion and administers to				
	·	proper hold. MHT #17				
	comes in. MHT #17 a					
		100. Resident refused				
		I. Doors shut everyone safe.				
		g shot while mouthing to 'I				
		ent a) a shot'. Resident				
		s Resident and sets				
		calmed by MM #8. Resident				
		) hall, door won't shut, and e side, staff pulling from the				
	, , ,					
		powered the staff. Almost all				
		hall. Free for all, kicking,				
		in hold with MM #8 in				
	, <u> </u>	et to Resident in hold.				
		down. Smacked nurses				
		ook almost 1 hour. Resident				
		. While in hold Resident				
	S.	Bargained with the boys to				
		ys walked off and went back				
		toring Resident , pulling				
		sick almost passing out.				
		iew revealed the staff are				
	expected to follow the	e '777' rule for resident				
		oants, 7 shirts, 7 underwear,				
	7 socks, etc. Interview	w revealed LPN #6 notified				
	RN #5 and AS #21, t	hen she calls 911 for police				
	assistance. Interview	v revealed "Resident				
	had a "weapon" (pied	ce of board with nails broken				

off table) and was arrested. Residen busted through the police and ran. was arrested.

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	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY PLETED
		MHL0601258	B. WING		01	/17/2018
	ROVIDER OR SUPPLIER	ER-CHARLOTTE 1715 SH	DDRESS, CITY, STATE ARON ROAD WES DTTE, NC 28210			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROS <b>S</b> -REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 512	Resident kicked to arrested. Interview rechange in staffing or and re-training on gerevealed the administration of 2 hours at the beshift on 01/10/2018 to revealed the meeting more in depth. Interview revealed so include the "new me between residents' hopen and activity confirmed in the confirm	was revealed there had been no a the units since the incidents ears/de-escalation. Interview strative staff met with them ginning of their 7pm-7am or review concerns. Interview grinformation needed to be view revealed the PRTF unit ecause nothing had changed. The identified safety issues dication pass process, doors hall being held or propped ming in."  1018 at 1540 with AS #23 and	V 512			
	interviewing staff who called. Interview revicalled. Interview revicameras and saw strevealed "I called the call the police, so I do C. Video review on 100/200/300 halls resecure doors betwee promote supervision 01/03/2018 at 0000 propped open with a 01/06/2018 at 0129 propped open with a (Mental Health Tech sitting in the 200 hal 01/06/2018 at 0130 propped open with a and #28 were walking the same walking and #28 were walking to the same same same same same same same sam	en they heard a Code Purple realed they looked at the aff need help. Interview a administrators who said to id."  01/17/2018 at 1640 of the evealed facility staffs failure to en twelve bed PRTF halls to of residents and safe care.  the 100/200 hall door was a door magnet. the 200/300 hall door was a door magnet and MHT inician) #12 and #17 were I way. the 100/200 hall door was a door magnet and MHT #15				

Division of Health Service Regulation

(X3) DATE SURVEY

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL0601258	B. WING		01/17/2018
NAME OF P	ROVIDER OR SUPPLIER	STREETAI	DDRESS, CITY, STATE,	ZIP CODE	
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE	ARON ROAD WEST OTTE, NC 28210	T	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE COMPLETE
V 512	magnet and MHT #28 01/10/2018 at 2000 th hall door were closed 01/11/2018 at 0052 th 200/300 hall door were 01/11/2018 at 0300 th 200/300 hall door were 01/13/2018 at 0158 th propped open with a control of the contro	the propped open with a door is was sitting in the 200 hall. The 100/200 hall and 200/300 hall and 200/200 hall and the re closed. The 100/200 hall and the re closed. The 100/200 hall door was adoor magnet. The 100/200 hall and 200/300 hall and	V 512		
	also stated that arouncome through the doctor through. The nurse some practice, every night, leave the doors open staff to staff the units.  Interview on 01/17/20 revealed the 100/200	e time. It was common definitely the standard to . There was not enough			
	while the MHT's comp	oleted chores and residents w revealed "doors are left			

(X2) MULTIPLE CONSTRUCTION

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
	MHL0601258	B. WING		01/17/2018					
NAME OF PROVIDER OR SUPPLIER	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
STRATEGIC BEHAVIORAL CENTER	-CHARLOTTE	ON ROAD WE	ST						
	CHARLOT	TE, NC 28210							
PREFIX (EACH DEFICIENCY)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE					
outside were not left op MHT #28 went to a cris	ding to the main corridor or open. Interview revealed sis management meeting re told not to leave doors  84922; NC00134623; 84699; NC00134620;	V 512							

Division of Health Service Regulation

# STRATEGIC BEHAVIORAL CENTER POLICY AND PROCEDURE MANUAL

		SUBJECT: Maintenance of Integrity of Patient hallways and units		
POLICY AND PROCED 1600.64	URE: Transitions	Page 1 of 2		
FUNCTIONAL AREA:		REFERENCES:		
Nursing				
EFFECTIVE DATE:		APPROVED BY: GOVE	RNING BOARD	
01/2018		02/2018		
REVIEWED/REVISED: 02/2018	REVIEWED/REVISED:	REVIEWED/REVISED:	REVIEWED/REVISED:	

#### PURPOSE:

To communicate the expectations related to strategies to increase the safety of patients and staff at Strategic Behavioral Center, Charlotte.

### POLICY:

- 1. While there may be structured activities where patients from more than one unit are allowed to interface with one another (i.e. Cafeteria, community groups, town halls, etc.), all hospital staff will ensure that, once on their assigned hallways, patients are maintained in their own designated care areas.
- 2. With the exception of an emergency such as a fire when evacuation may be required and is being authorized by the CEO or Safety Officer, the doors between hallways will not be kept propped open by staff. This will prevent the inadvertent mixing of patient populations and sequelae such as patient to patient violence or patient to staff violence.
- 3. Before entering patient hallways, staff will ensure that patients are not near the door and are attempting to elope from the area or commit other unsafe behaviors.
- 4. When staff are moving from one patient area to another, they will ensure that the door is closed to the patient hallway behind them before leaving the door area and that unauthorized patients do not follow them from the hallway or other patient area.
- 5. Staff will ensure that doorways between patient units/hallways and to central corridors are kept secured.
- As part of their responsibilities, at the start of each shift, MHT staff will ensure that the doors of all hallways, exits are secured by walking around and checking them for integrity.
- 7. Staff will assess the security of doors to patient hallways whenever there is a question that they may have, somehow been compromised by damage to same.

### PROCEDURE:

# STRATEGIC BEHAVIORAL CENTER POLICY AND PROCEDURE MANUAL

DEPARTMENT: Nursi	ng Services	SUBJECT: Maintenance of Integrity of Patient hallways and units		
POLICY AND PROCED 1600.64	URE: Transitions	Page 2 of 2		
FUNCTIONAL AREA:		REFERENCES:		
Nursing				
EFFECTIVE DATE:		APPROVED BY: GOVE	RNING BOARD	
01/2018		02/2018		
REVIEWED/REVISED: 02/2018	REVIEWED/REVISED:	REVIEWED/REVISED:	REVIEWED/REVISED:	

- 1. Before entering corridors where patients are situated, look through window of doorway to ensure patients are not at door and may be waiting to elope.
- 2. When leaving corridors to where patients are situated, ensure that the door closes before patients may leave who are not authorized to do so.
- 3. Do not prop open doorways between hallways and corridors with the exception of an emergency when evacuation has been authorized by the CEO or Safety Officer.
- 4. At the start of each shift, and whenever there is a question on the integrity of a door, MHT to accomplish a check of all exits to ensure that doors are secured.

Division of Health Service Regulation STATE FORM