Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	A. BUILDING: _____ B. WING _____	01/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE	1715 SHARON ROAD WEST 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 000	INITIAL COMMENTS A complaint investigation was conducted January 8, 2018 through January 12, 2018 and January 16, 2018 to January 17, 2018 to determine the facility's compliance with the state rules for licensing Psychiatric Residential Treatment Facilities (PRTF). The investigation resulted in the identification of an imminent threat to residents as evidenced by a systemic failure to provide safe delivery of care to adolescent behavioral health patients. Facility staff neglected to communicate resident's behavioral health history to include but not limited to violence, homicidal, suicidal, elopement, history of running away, physically assaultive, verbally assaultive and property damage to care staff thereby creating an unsafe environment that allowed opportunities for residents to destroy wood furniture and create weapons used to threaten staff. Facility staff neglected to implement policies, procedures, elopement precautions and supervise residents with a known history of eloping and running away. Ten residents eloped from the facility on January 1, 2018, which required police intervention. Subsequently, on January 5, 2018, police protection (eleven police officers) was required to secure the facility and create a safe environment which resulted in six adolescent residents being handcuffed and three of the six adolescent residents being arrested. The facility's administrative staff was notified on January 10, 2018 at 1615 of the identification of the imminent threat beginning on January 1, 2018. Based on the action plan submitted and the lack	V 000	Please know that SBC, Charlotte is profoundly humbled by this occurrence and takes these findings seriously. It has, subsequently implemented a comprehensive corrective action plan to address. The corrective actions are delineated in the following pattern: *The root cause (contributing factors)s of the deficiencies in systems identified and for each:* *a)The procedure for implementing the acceptable plan of correction for the specific deficiency identified;* *b)The date by which all corrective actions will be completed and the monitoring system will be in place.* *c) The title of the person responsible for implementing the acceptable plan of correction* *d)The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.*	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[redacted],	CEO	2/13/2018

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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. Pursuant to North Carolina General Statutes N.C.G.S. § 122C-23, the Division of Health Service Regulation (DHSR), North Carolina Department of Health and Human Services (DHHS), HEREBY SUSPENDS ADMISSIONS.	V 000		
V 105	.0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201. GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the	V 105	V 105 GOVERNING BODY POLICIES Failure of the governing body to ensure a safe environment for the delivery of care to adolescent behavioral health residents #1, #2, #11, #7, #12, #9, #10, #8, #3, and #6 by not communicating the resident's behavioral health history to include but not limited to violence, homicidal, suicidal, elopement, history of running away, physically assaultive, verbally assaultive and property damage to care staff thereby creating an unsafe environment	

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V 105	Continued From page 2 operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a	V 105	*The corrective action is written in the following format:* *The root causes (contributing factors) of the deficiencies in systems identified, and for each:* *a)The procedure for implementing the acceptable plan of correction for the specific deficiency cited;* *b)The date by which all corrective action will be completed and the monitoring system will be in place.* *c) The title of the person responsible for implementing the acceptable plan of correction* *d)The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.* **Root cause (contributing factor):** **1)Criteria for admission did not exclude patients with history of aggressive behavior, elopement, or pending legal charges** (a) The criteria for admission to the PRTF for SBC Charlotte have been revised to now exclude patients with history of felonious behavior, history of elopement from a facility, history of gang involvement, history of substance abuse disorder, and history of a conflict or affiliate relationship with a current resident of SBC Charlotte. Attachment "A" shows the revised criteria for SBC, Charlotte, PRTF. SBC Charlotte is currently evaluating if these same criteria will be applied to patients within the acute care setting.	01/26/18

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V 105	Continued From page 3 determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on policy review, medical record review, video review, police report review and staff interview, the facility's governing body neglected to ensure a safe environment for the delivery of care to adolescent behavioral health residents #1, #2, #11, #7, #12, #9, #10, #8, #3, and #6. Facility staff neglected to communicate resident's behavioral health history to include but not limited to violence, homicidal, suicidal, elopement, history of running away, physically assaultive, verbally assaultive and property damage to care staff thereby creating an unsafe environment that allowed opportunities for residents to destroy wood furniture and create weapons used to threaten staff. The findings included: Review on 01/09/2018 of policy title "Code Purple" last Reviewed/Revised 12/2016 revealed "Policy: To correctly identify steps to be utilized in the event of a Code Purple (psychiatric emergency) ...1. A group of RAs will be identified	V 105	**(b) Date of Completion:** Approved by the Governing Board 01/ 26 /2018 and now in place for PRTF units. **(c) Responsible Person:** Chief Executive Officer **(d) Monitoring Procedure to Ensure Correction:** 1) (a) (1) All admissions will be reviewed by the Admissions Coordinator and the CEO for evidence of compliance with exclusionary criteria. (a) (2) On a weekly basis, SBC, Charlotte will conduct a PRTF Performance Improvement (PI)Committee meeting. A Governing Board Member will be a weekly participant to hear the results presented at this meeting. Attachment "B" delineates the standing agenda for this meeting. One of the indicators for review will be compliance with the exclusionary criteria for all prospective admissions. The results, conclusions, and recommendations 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. **Root cause (contributing factor):** **2)Patient details of prior history were not always present at the time of the initiation of the treatment plan and, thus, incorporated into same.** (a)(1)) A hand-off form and formalized procedure 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	2/18/18

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V 105	Continued From page 4 on each shift to be a part of the Code Purple Team ... 3. When a staff member notes that a resident is exhibiting signs of escalated behavior ... the Code Purple will be announced over the walkie-talkie with the location attached to the code ... 7. Code Purple team members will arrive at the announced location and take direction and cues from the primary staff member on the scene ... 9. The primary staff member on the team will work collaboratively with the RN to de-escalate the resident. 10. Based on the level of danger to self/others, the primary staff and RN will cue the Code Purple team members into position if there is a need for physical restrictive intervention. ..." Review on 01/09/2018 of policy title "Position Summary - Registered Nurse" Date Approved: 01/31/2015 revealed "...The Registered Nurse...May assume a coordinating or supervisory role with assigned licensed nursing and milieu personnel i.e. assignments, monitoring schedule/work, follow-through and high acuity direction...Effectively respond and actively participate in a psychiatric crisis to resolution...Therapeutic Milieu 2. High visibility during increased acuity and takes an active role with indicated interventions..." Review on 01/10/2018 of the facility policy titled "Elopement" reviewed/revised on 12/2016 revealed "...will maintain a safe and secure therapeutic milieu for all clients receiving inpatient treatment. Procedure: 1. In the event of an elopement, the code, 'CODE GREEN' and location will be announced over the intercom. 2. Call (Name) police department immediately. Give names of the clients. Have a description of the escaped client - name, height, weight, sex, and age. When the police arrive give a copy of the photo ID of the client from the chart. 3. The RN	V 105	precautions shall be written on the form entitled: "High Risk/High Alert Hand-off" and must be handed to the receiving nurse for their acknowledgement and signature of same. Report on precautions must be provided verbally (in person or per telephone) to the receiving Unit nurse prior to the patient being integrated into the nursing unit environment. The Unit nurse, in turn, will be responsible for implementing all orders and processes that accompany the specific precautions. Attachment "C" delineates the hand-off form and associated policy. During daily Administrator on Call rounds, the AOC will check the 15-minute check sheets for evidence of appropriate stickers signifying patient safety precautions that must correspond with those precautions identified by the High Risk/High Alert Hand-Off and, as ordered by the patient's physician. Deficiencies noted will be immediately corrected. Staff not meeting these requirements will be addressed on a progressive disciplinary basis. All intake assessment staff and nursing staff with patient care responsibilities are being trained through inservice activities on these requirements. 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. Staff not meeting these requirements for use of the hand -off form and procedure will be addressed on a progressive disciplinary basis. **(b) (1) Date of Completion:** 02/18/2018 **(c)(1) Responsible Person:** Director of Admissions and Referral	

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V 105	Continued From page 5 will immediately notify the client's physician, the Medical Director, the Administrator on Call, and the client's legal guardian ...6. When the resident is located, the RN will notify the physician for a determination of whether the resident is to be evaluated at the Emergency Department prior to return to the facility. 7. The client will immediately be placed on elopement precautions ... and the attending physician will be consulted for any further orders." Review on 01/10/2018 of the facility policy titled "Elopement Precautions" reviewed/revised 12/2016 revealed "... Residents who talk of running away, participate with or know of a planned runaway or actually run away will be placed on elopement precautions ...Procedure ...2. The adolescent who returns from an elopement must write a detailed narrative describing the events prior to the run, the run itself, and what transpired while the resident was away. This narrative must complete prior to the client being removed from elopement precautions. The narrative should include an effort to discover an alternative manner of coping, other than running away. 3. Adolescents on elopement precautions will have a bedtime of 8:30 pm every night. 4. Adolescents will be provided foam slippers to use as footwear. No shoes will be permitted. 5. Residents will not be allowed to leave the unit. 6. The individual's treatment plan will be modified to reflect the interventions necessary to maintain safety, i.e. room search daily, limited phone calls. 7. A physician's order will be required to remove the resident from elopement precautions. 8. Criteria for advancement from elopement precautions include: no dangerous behavior to self or others, no sneaky or suspicious behavior, compliance with rules/medications, the willingness to talk with	V 105	**(d). Monitoring procedure to ensure correction 2)** (a)(1) During daily Administrator on Call rounds, the AOC will check the 15-minute check sheets for evidence of appropriate stickers signifying patient safety precautions that must correspond with those precautions identified by the High Risk/High Alert Hand-Off and, as ordered by the patient's physician. Deficiencies noted will be immediately corrected. 100% of patient admissions will be reviewed at the weekly SBC Charlotte PRTF PI Committee meeting to review for compliance with use of the "High Risk/High Alert Hand-Off form. A Governing Board Member will be a weekly participant to hear the results presented at this meeting. The findings, conclusions, recommendations, and actions 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. (a)(2) A patient safety notification system has been developed whereby all patients on the PRTF are having identification stickers that are color- coded with level of precautions placed on their 15-minute round sheets. According to this system, based on their identified safety need, patients will have a red, yellow, or green level of precaution assigned. For example, patients on elopement precautions will be identified on their 15-minute check sheet as such and staff must ensure that they adhere to all provisions of the Elopement policy including restriction on outdoor activities, as ordered by the patient's physician. Attachment "D" delineates the new process for patient safety notification. During daily Administrator on Call rounds, the AOC will check the 15-minute check sheets for	2/18/18

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V 105	Continued From page 6 staff regularly about concerns/feelings." Review on 01/11/2018 of the facility policy titled "Admission Procedures" reviewed/revised 12/2016 revealed " ...B. Belongings are to be itemized on the belonging list when brought to the unit ...C. Patient may keep at bedside a 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 location ...5. 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 documentation will facilitate the recording of accurate, timely data, which reflects the current status of the client, the care provided, and he progress made by the client. Procedure ...2. 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 Nurse will document ...summary documentation will be completed every seven days ...incident charting will be completed. The weekly/ daily nursing notes will include the individual response to meds, any side effects and relevant lab values. 4. Incident charting includes any circumstances involving the client, which indicate an immediate or unexpected change of status. Some examples	V 105	Evidence of appropriate stickers signifying patient safety precautions that must correspond with those precautions identified by the High Risk/High Alert Hand-Off and, as ordered by the patient's physician. Deficiencies noted will be immediately corrected. Staff not meeting these requirements will be addressed on a progressive disciplinary basis. All nursing staff with patient care responsibilities are being trained through inservice activities on these requirements. 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. Staff not meeting these requirements for use of the hand -off form and procedure will be addressed on a progressive disciplinary basis. **(b)(2) Date of Completion:** 02/18/2018 **(c) (2) Responsible Person:** Director of Nursing **(d) Monitoring procedure to ensure correction** (a)(2) During daily Administrator on Call rounds, the AOC will check the 15-minute check sheets for evidence of appropriate stickers signifying patient safety precautions that must correspond with those precautions identified by the High Risk/High Alert Hand-Off and, as ordered by the patient's physician. Deficiencies noted will be immediately corrected. The findings will be summarized at the Hospital's Morning Meeting of leadership staff. The findings will be aggregated and reviewed at the weekly PRTF PI Committee. A Governing Board Member will be a weekly participant to hear the results presented at this meeting. The findings, conclusions, recommendations, and actions 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.	

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V 105	Continued From page 7 include ...injuries, special treatment procedures ... and self-abusive behaviors. 5. Summary documentation is directed at recording progress toward achieving the measurable treatment plan goal. Summary documentation should include ...Client's mental status, physical status, behavior in the therapeutic milieu, mood, affect, medication compliance and response, appetite and intake, percent of weight gain or loss, grooming and hygiene, quality of sleep, nursing interventions, current nursing care being provided, and any restrictive interventions needed ...7. Staff will document the client's location on the observation sheet every 15 minutes ..." Review of a local "Police Department Incident Report" revealed the police were called on 01/01/2018 at 2156 to assist with an assault to MHT #10, property damage and ten missing persons listed as Resident #8 ([redacted] Resident #9 ([redacted] Resident #10 ([redacted] Resident #2 ([redacted] Resident #1 ([redacted] Resident #6 ([redacted] Resident #11 ([redacted] Resident #12 ([redacted] Resident #3 ([redacted] and Resident #7 ([redacted] A.1. Open medical record review on 01/09/2018 for Resident #1 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) on [redacted]/2017 with diagnoses of [redacted] Review of the intake assessment revealed the resident [redacted] Admission vital signs were [redacted] Review of the Psychiatrist Evaluation documented on	V 105	**Root cause (contributing factor):** **3) Information of incoming patients and prior placements with other patients was not always known to the facility. History of patterns of elopement and history of violent behaviors were not always communicated.** (a)Part of the query of the intake assessment now compares prior placements of prospective residents to those residents currently in house. If there is evidence learned of a prospective resident having resided at the same facility of a current resident, a further inquiry regarding relationship between the two will be obtained and documented before accepting the new resident. Prospective residents with determined histories of conflict with a current resident or having affiliated with a current resident will be excluded from admission. All intake assessment staff are being trained through inservice activities on these requirements. 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. Staff not meeting these requirements will be addressed on a progressive disciplinary basis. **(b) Date of Completion**: Approved by the Governing Board 01/ 26 /2018 and now in place for PRTF unit **(c) Responsible Person**: Chief Executive Officer **(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 affiliation with a current resident. On a weekly basis, SBC, Charlotte will conduct	1/26/18

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V 105	Continued From page 8 [redacted]/2017 at 2050 revealed "[redacted]" Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #1 had the following risk and history of violence: "[redacted]" 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 the medical record revealed documentation of a [redacted] for Resident #1 on [redacted]/2[redacted], a [redacted] on [redacted] from [redacted] for [redacted], a [redacted] on [redacted]/[redacted] from [redacted] for [redacted] and a [redacted] on [redacted]7 from [redacted] for [redacted]. Review of facility video recordings on 01/10/2018 of residential hallways on 01/1/2018, revealed Resident #1, fully dressed in [redacted]. Review of the record revealed a nursing shift note dated 01/01/2018 at 2035 that recorded "[redacted]"	V 105	a PRTF Performance Improvement (PI)Committee meeting. A Governing Board 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. **Root cause (contributing factor):** **4)The treatment plans did not always reflect individualized patient information including elopement history, violence history, and strategies to prevent. An audit for same was not in place to identify deficient entries.** (a)(1) All staff with responsibility for completion of the treatment plan ae being instructed through inservice education on the requirement to include all patient information that will be necessary to formulate an effective initial treatment plan for the resident. Information shall include elopement and violence history, suicide precautions, and any precautions that may impact the resident's safety and the safety of other residents and staff. Compliance with this responsibility will be evaluated daily (M-F) as part of the Hospital's Morning Leadership meeting (see monitoring section for description). Deficiencies noted will be updated within one hour of discovery. Staff not meeting these requirements will be addressed on a progressive disciplinary basis. 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.	2/18/18

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V 105	Continued From page 9 [redacted] Record review revealed a 7pm-7am nursing note dated 01/01/2018 at 2100 that recorded "[redacted] Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room [redacted] on 01/01/2018. 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 "[redacted] Review of the Observation Sheet dated 01/02/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at "[redacted] Review of the night shift notes recorded by MHT #16 revealed the resident was "[redacted]	V 105	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 **(c)(1) Responsible Person**: Director of Clinical Services a)(2) All staff with responsibility for completion of 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 residents and staff. 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. 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. 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. **(b)(2) Date of Completion**: 02/18/2018 **(c) (2) Responsible Person**: Director of Clinical Services	2/18/18

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V 105	Continued From page 10	V 105	**(d)Monitoring procedure to ensure correction** 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 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 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 Leadership Staff, Monday through Friday. 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 at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date.

[redacted]
Review of the medical record on 01/09/2018 revealed no documentation of a nursing assessment in the record after the resident was returned from elopement. Review of the record on 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at 0015 that recorded the resident [redacted]. Note recorded that [redacted]
Review of nursing note dated 01/02/2018 at 1430 revealed "[redacted] Review of telephone orders dated 01/02/2018 not timed revealed orders to place Resident #1 on [redacted] for [redacted] and to [redacted] and [redacted]

[redacted] orders dated 01/02/2018 at 2050 revealed a telephone order for [redacted] (medication for behavior) [redacted] as needed for [redacted] Review of a Case Management Note documented by the Director of Clinical Services (DCS), dated 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 [redacted]. Note recorded the DCS and the DON questioned

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V 105	Continued From page 11 client about any injuries, pain or other concerns. Note recorded the DCS set expectations for resident's return to the unit. Note recorded the client was assessed by a Registered Nurse (RN). Review of the Psychiatrist progress note dated 01/04/2018 at 1237 revealed "[redacted]" Review of a Health Incident Review Report for Resident #1 completed by RN #2 and dated 01/01/2018 recorded "[redacted] Review of the report revealed the date and time of the elopement was 01/01/2018 at 2155. Review of a Health Incident Review Report for Resident #1 completed by RN #4 on 01/02/2018 recorded "[redacted]	V 105	**Root cause (contributing factor):** **5) The prior CEO had erroneously communicated to staff to not involve the Police in patient situations.** (a) All Hospital staff are now receiving training specific to the 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 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. 100% of key events including restrictive interventions, aggressive acts of patients to patients 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 Police Dept. will occur. Staff not meeting these requirements after re-training will be addressed on a progressive disciplinary basis.	Meeting with Police 1/17/18 Trng and re-trng on policy completed 2/18/18

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V 105	Continued From page 12	V 105	(b) **Date of Completion:**	

[redacted]"

Review of a Health Incident Review Report for Resident #1 completed by RN #5 and dated 01/02/2018 recorded "([redacted] Review of the report revealed the date and time of the incident was 01/02/2018 at 1321.

Review of the Medication Administration Record revealed no available documentation of [redacted] administered on 01/02/2018. Review of Restrictive Intervention documentation dated 01/02/2018 at 1321 revealed a physician order for [redacted] for [redacted] and [redacted] Resident [redacted] and [redacted]. Resident [redacted] Restrictive intervention documentation revealed Resident #1 was [redacted] on [redacted] 2/2018 at [redacted], then a [redacted] at [redacted] and [redacted] at [redacted] Restrictive Intervention documentation revealed Resident #1 was administered [redacted] at [redacted]

Interview on 01/12/2018 at 1015 with RN #5 revealed Resident #1 was the [redacted] resident escorted to [redacted] room at [redacted]. Resident #1 had a [redacted]

Meeting with Charlotte Police Dept.: 01/17/2018

Completion of training on policy for all SBC Charlotte staff:

02/18/2018

(c) Responsible person: Director of Compliance/Quality/Risk

(d) Monitoring procedure to ensure correction

5) Compliance will be monitored as follows:
A 100% review of key events including restrictive interventions, aggressive acts of patients to patients 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 contacted, when indicated. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 at each of their respective meetings.

This process will continue as presented on a go-forward basis and has no end date.

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V 105	Continued From page 13 Interview on 01/12/2018 at 1015 with RN #5 revealed Resident #1 was admitted to the [redacted] hall due to elopement risk. Interview revealed [redacted] Interview revealed we [redacted] 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 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) on [redacted]/2017 as [redacted] Review of the record revealed admission diagnosis included [redacted] Review of admissions information titled "Clinical Evaluation/Diagnostic Assessment" dated [redacted]/2017 recorded by a [redacted] revealed [redacted] Review revealed the resident has [redacted] Review revealed on [redacted] the resident [redacted]. The resident was [redacted] Review of a Comprehensive Psychosocial Assessment Tool documented by a [redacted] on [redacted]/2017 (not timed) recorded the resident [redacted]	V 105	**Root cause (contributing factor):** **6) There was no prior experience of what evolved into a patient riot or actions to take** (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** 6) 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	All elements 2/18/18

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V 105	Continued From page 14 "[redacted]." Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #2 had the following risk and history of violence: "[redacted]." 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 #2, fully dressed in [redacted] Review of admission orders dated [redacted]/2017 revealed the resident was placed on [redacted] with every 15 minute observation checks. Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room [redacted] on 01/01/2018. 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 [redacted]:" (location not defined) from [redacted]; [redacted]; [redacted]" (location not defined). Review of the night shift notes recorded by MHT #14 revealed the resident was returned from elopement and placed on every 15 minute room checks. The notes recorded that the resident was given [redacted] and [redacted] Review of nursing notes documented by RN #2 on 01/01/2018 at 1920 recorded the resident's [redacted] was [redacted] and [redacted] was given [redacted] Notes recorded "[redacted]	V 105	report) to assess if the Riot Management plan was followed including if the Police were contacted, when indicated. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 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):** **7) The windows between units had been required by another oversight agency to be occluded. As a result, staff were unable to see what was occurring behind a hallway door without opening it.** **(a)** The frosting on the windows has been removed. All Hospital Staff with patient care responsibilities are being inserviced to look through the window before moving from one unit to another and to not open the door if, in doing so, patients can spill over 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 unit.	1/10/18 frost from windows removed 2/18/18 all elements

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V 105	Continued From page 15 [redacted]." 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 the resident returned to the facility [redacted]. Notes recorded the resident was "[redacted]." Record review revealed the resident was searched and dressed in paper scrubs upon return to the facility on 01/02/2018. Review revealed the resident was placed on [redacted] upon return. Review of nursing notes documented on 01/02/2018 at 1400 recorded "[redacted]." Review of a psychiatrist progress note dated 01/04/2018 at 1242 recorded the patient admitted to [redacted], stating that [redacted]. Review of the notes revealed "[redacted]..."	V 105	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. 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. This expectation has been incorporated into the Hospital's orientation. Compliance with the process is being evaluated with all patient events and as a part of daily monitoring for compliance with expectations whereby camera 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. **(b) Date of Completion:** Frosting removed from windows: 1/10/18 Education on expectations related to looking through the doorways before entering a patient unit: 02/18/2018 "Own the door" campaign training completed: 02/18/2018 Camera review process in place as of: 02/18/2018 Content on safety expectations in place in orientation as of: 02/18/2018 **(c) Responsible Person:** Safety Officer	

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V 105	Continued From page 16 Review of Health Incident Review Report for Resident #2 completed by RN #2 and dated 01/01/2018 recorded "[redacted]." Review of the report revealed the date and time of the elopement was 01/01/2018 at 2155. Interview on 01/12/2018 at 1015 with RN #5 revealed Resident #1 was admitted to the [redacted] hall due to [redacted]. Interview revealed we [redacted] Interview revealed we [redacted]. Resident #1 said [redacted] Interview revealed from that point forward Resident #1 and Resident #2 were not to be on the same hall together. 3. Open medical record review of Resident #11 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted], anger issues. Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #11 had the following risk and history of violence: "[redacted]." Based on the medical record review there was no evidence available to determine facility staff implemented a	V 105	**(d) Monitoring procedure to ensure correction** 7) On a daily basis, during the Safety meetings, the doorways of all PRTF nursing units will be reviewed per camera on a Monday through Friday basis with the results of Friday, Saturday, and Sunday incorporated into Monday's report) to assess if staff are looking through the windows before entering patient units. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 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):** **8) A central medication room was being utilized for medication administration versus medication administration occurring on the individual patient units. While patients of the unit in which the medication room is situated were not to be on the unit at the time other patient groups were brought there, this process was not consistently being followed, which allowed some inadvertent mixing of patient populations.** (a) The use of the one medication room for medication dispensing was discontinued and staff prohibited from utilizing this system . All nursing staff with medication administration responsibilities are being instructed to dispense medications on their individual nursing units.	1/4/18- med pass equipment in place 2/2/18 200 med room fully dc'ed for meds 2/18/18- med audits in place

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V 105	Continued From page 17 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 #11, fully dressed in [redacted]. 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 dated 01/01/2018 revealed the resident was assigned to Room [redacted] 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 "[redacted]" from [redacted]; then "[redacted] from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted] then "[redacted]" from [redacted] Review of Night shift notes recorded by MHT #17 revealed "[redacted]." Review of notes at 2202 revealed "[redacted]." A nursing note by RN #1 on 01/02/2018 at 0000 recorded "[redacted]	V 105	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. This process and associated expectations has been incorporated into the Hospitals Nursing orientation. **(b) Date of completion:** Discontinuation of the central medication station for medication administration: 02/02/2018 Implementation of the medication audits: 02/18/2018 **(c) Responsible person:** Director of Nursing (d) Monitoring procedure to ensure correction 8) On a weekly basis, the Director of Nursing or trained delegate will observe a medication pass on every shift to assess if the requirements related to medication administration are being followed including restriction to medication administration confined to each patient's own unit. The findings of this review 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. This process will continue as presented on a go-forward basis and has no end date.	

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V 105	Continued From page 18	V 105	**Root cause (contributing factor):** **9) The furniture in use at the hospital, to date, had never been stressed to the point of being broken.** (a) The desks that were broken by the residents and separate boards used to devise weapons were removed from the environment.	1/11/18 Furniture removed and reinforced

[redacted]."
Nursing notes documented by RN #5 dated 01/02/2018 at 1330 recorded "[redacted]." Notes at 2200 recorded the resident was transported to a [redacted] for evaluation and returned from [redacted] on 01/03/2018 at [redacted]. Notes revealed the resident had [redacted] and [redacted] Notes revealed [redacted] medication was administered. Review of an LPN note dated 01/02/2018 at 0050 recorded "[redacted]."

Review of the medical record on 01/10/2018 revealed no further documentation of a nursing assessment in the record after return from elopement on 01/01/2018. Review on 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded "[redacted]"...

Chairs containing the same design with slats that were broken off were reinforced with hardware (that, itself, cannot be compromised) to increase their strength and reduce the chance of being dismantled through the application of force.

1/23/18 Rounds in place

A prototype desk has been devised that has solid 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 as a weapon.

2/7/18 Prototype desk devised

All staff with patient care responsibilities are being advised through inservice education that, when furniture or other objects are being broken by a patient to use as weapon, and such a weapon is 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.

2/18/18 Trng and Re-trng completed

Additionally, all staff with patient care responsibilities are being advised through inservice education on the expectation to assess for the integrity of furniture in the patient care environment at the start of each shift and to remove and secure furniture that appears to have been compromised or that may pose a possible risk for being broken.

In order to remain on the schedule, staff not in attendance for the inservice are required to receive

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V 105	Continued From page 19	V 105		

[redacted]

4. Closed medical record review of Resident #7 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted].

Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #7 had the following risk and history of violence: "[redacted]." 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 #7, fully dressed in [redacted].

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 dated 01/01/2018 revealed the resident was assigned to Room [redacted] 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 "[redacted]" from [redacted]; then [redacted] from [redacted]

training on this requirement prior to any scheduled 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

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 rounds in place as of: 02/23/2018

(c) Responsible person: Director of EOC
(d) Monitoring procedure to ensure correction

9) Compliance with the corrective actions will be accomplished as follows:
On a daily basis (M-F), the EOC Director will conduct rounds in all resident care areas to ensure that the furniture is secure, and that there is evidence of no 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 assess the integrity of all furniture in the PRTF patient care areas prior to the start of each shift.

Any items that appear to have been compromised or that may pose a possible risk for being broken will be immediately removed from the environment and not returned until repaired or replaced.

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V 105	Continued From page 20 [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted]. Review of Night shift notes recorded by MHT #13 revealed "[redacted]" Review of nursing notes documented by RN #1 dated 01/01/2018 at 2015 revealed the resident was [redacted] and offered and refused prn (as needed) medication [redacted]. Review of notes at 2202 revealed "[redacted]." A nursing note by RN #1 on 01/02/2018 at 0000 recorded "[redacted]." Review of nursing notes documented by an LPN dated 01/02/2018 at 0130 recorded "[redacted]." Nursing noted "[redacted]." Nursing notes documented by RN #5 dated 01/02/2018 at 1300 recorded "[redacted]." Notes at 2200 recorded the resident was transported to [redacted] for evaluation and	V 105	Compliance with this process and the findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. These findings, conclusions, and actions taken 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. This process will continue as presented on a go-forward basis and has no end date. **Root cause (contributing factor):** **10) The medical record audit process was not capturing time/date omissions, assessments and re-assessments not documented, as required. Similarly, the performance improvement review process was not capturing the review for compliance with items including treatment plan content against patient precautions and re-assessments per expectation.** (a) All SBC Charlotte Hospital leadership staff with responsibilities within their departments for medical record documentation have been re-educated on the specific requirements for the medical record components including: but not limited to: (1) Dating/timing of orders within requirements (2) Frequency of documentation (3) Medications documented as ordered (4) Completion of assessments and reassessments per time requirements (5) Frequency of MD Progress Notes (6) Co-signature by MD after Seclusion and Restraint within 24 hours These items are in addition to those otherwise noted in this report.	2/18/18 All elements in place

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V 105	Continued From page 21 returned from [redacted] on 01/03/2018 at [redacted] Notes revealed the resident had [redacted] and [redacted]. Notes revealed [redacted] was administered. 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 "([redacted]" Record review revealed the resident was discharged on 01/03/2018. 5. Open medical record review of Resident #12 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted] Review of a Comprehensive Psychosocial Assessment Tool completed by a [redacted] on [redacted]/2017 at 1703 revealed the patient had a "[redacted]" 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 [redacted]. Review of admission orders revealed the resident was placed on every 15 minute observations and	V 105	All SBC Charlotte Hospital and Medical staff with responsibility for documentation have been reminded through meetings and written memoranda of the requirements for documentation, as delineated above. All SBC Charlotte Hospital leadership staff with responsibilities within their departments for medical record documentation have been re-educated on the medical record audit process and associated expectations for its completion. 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. **(b) Completion Date:** Re-education of Hospital and Medical Staff: 02/18/2018 Re-education of Hospital leaders on requirements: 01/31/2018 Initiation of intensified audits: 02/01/2018 **(c) Responsible Person:** Director of Compliance/Quality/Risk **(d)Monitoring procedure to ensure correction:** 10) a) 100% audit of medical records will occur over the course of the week against medical records including compliance with: (1) Dating/timing of all orders (2) Frequency of documentation (3) Medications documented as ordered (4) Completion of assessments and reassessments per time requirements (5) Frequency of MD Progress Notes (6) Co-signature by MD after Seclusion and Restraint within 24 hours	

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V 105	Continued From page 22 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 Room [redacted] 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 "[redacted]" from [redacted] then "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted] Review of Night shift notes recorded by MHT #16 revealed "[redacted] ..." 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 and stated it was not accurate. The nurse stated it was documented that the resident was in the [redacted] at 2300, but he didn't return until 0000. "She couldn't have laid eyes on the resident[redacted] wasn't back yet. I don't know why	V 105	The findings of this audit will be reported on, at least, a weekly basis at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date.	

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she documented that. It isn't correct."

6. Open medical review on 01/11/2018 of Resident #9 revealed a [redacted] admitted to the PRTF unit on [redacted]/2017 due to [redacted]. Review of the Intake Assessment dated 11/06/2017 revealed Resident #9 was at risk for elopement with a history of "[redacted]." 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 [redacted].

Review revealed Resident #9 lived on the [redacted] hall. Review of a nursing note dated 01/01/2018 at 2120 revealed Resident #9 "[redacted]. 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 [redacted] was "[redacted]" Review revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded "[redacted].

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[redacted]". Review of a physician order dated 01/02/2018 revealed Resident #9 was placed on [redacted]. 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 [redacted]" Review revealed Resident #9 stated "[redacted]."

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 [redacted] along with other peers.

7. Open medical record review on 01/10/2018 for Resident #10 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) from [redacted] on [redacted]/2017 with a diagnosis of [redacted]. Review of the nursing notes revealed Resident #10 arrived on the PRTF unit at [redacted]. Review of nursing notes revealed the resident was [redacted], with no complaints of pain or discomfort. Review of the nursing notes revealed the resident had old injuries noted to [redacted]. Admission vital signs were [redacted]

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[redacted]. Review of the intake assessment revealed the resident was currently [redacted]. Further review of the intake assessment revealed documentation of elopement risk related to [redacted].

Further review of the "Admission Intake Assessment Form" dated 12/22/2017 stated Resident #10 had the following risk and history of violence: "[redacted]." 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 [redacted]

Review of the record revealed a nursing note documented by RN #1 dated 01/01/2018 at 2045 that recorded "[redacted]." Review of the record revealed a note documented by RN #1 dated 01/01/2018 at 2202 that recorded "[redacted]" Review of the record revealed a note documented by RN #1 dated 01/02/2018 at 0000 that recorded [redacted]." Review of an Observation Sheet dated 01/01/2018 revealed the resident was

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assigned to Room [redacted] on 01/01/2018. 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 "[redacted] at [redacted], at [redacted] from [redacted], at 2. [redacted] at [redacted] at [redacted]: [redacted] from [redacted] and at [redacted] from [redacted]. Review of the Observation Sheet dated 01/02/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at "[redacted]. Review of the night shift notes recorded by MHT #16 revealed the resident "[redacted]." 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 [redacted] that recorded the resident returned to the facility [redacted]. Note recorded the resident was "[redacted]." Note recorded that [redacted]." Review of telephone orders dated 01/02/2018 not timed revealed orders to place Resident #10 on [redacted] for [redacted] and to [redacted] and [redacted] 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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signed as "Late Entry" on 01/03/2018 not timed revealed she met with the client, the Director of Nursing (DON) and the Milieu Manager (MM) after the resident was returned to the facility [redacted]. Note recorded the DCS and the DON questioned client about any injuries, pain or other concerns. Note recorded the DCS set expectations for resident's return to the unit. Note recorded the client was assessed by a Registered Nurse (RN). Review of the Psychiatrist progress note dated 01/04/2018 at 1249 revealed " ... [redacted]."

Review of a Health Incident Review Report for Resident #10 completed by RN #1 and dated 01/01/2018 recorded "[redacted]." Review of the report revealed the date and time of the elopement was 01/01/2018 at 2155.

8. Open medical record review of Resident #8 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted]. Review of a Comprehensive Psychosocial Assessment Tool completed by [redacted] on [redacted]/2017 at 1000 revealed the patient stated, "[redacted]." Review of admission orders revealed the resident was placed on every 15 minutes observation and

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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 Room [redacted] 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 "[redacted]" at [redacted]; then "[redacted] from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" at [redacted] then "[redacted]" from [redacted]; then "[redacted]" from [redacted]. Review of Night shift notes recorded by MHT #13 revealed "[redacted]..."

Review of nursing notes documented by RN #1 dated 01/01/2018 at 2030 revealed the resident was involved in [redacted] and redirected by staff multiple times. Review of notes at 2202 revealed "[redacted]" A nursing note by RN #1 on 01/02/2018 at 0000 recorded "[redacted]." Review of the medical

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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 "[redacted]." Review of a psychiatrist note dated 01/06/2018 at 1054 revealed "[redacted]"

Review of a Health Incident Review Report for Resident #8 dated 01/01/2018 at 2155 revealed "[redacted] ..."

9. Closed medical record review of Patient #3 on 01/09/2018 revealed a [redacted] admitted to the PRTF on [redacted]/2017 as a [redacted]. Review of the record revealed the admission diagnosis was [redacted]. Review of a nursing note dated 01/01/2018 timed at 1031 revealed a blank "Nursing Shift Note." Review of a restrictive intervention on 01/01/2018 from [redacted] to [redacted] revealed Resident #3 was placed in a [redacted] from [redacted] to [redacted] because [redacted]" Review of a nursing note (not dated) and timed at 2145 revealed [redacted]

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[redacted]" Review of the Observation Sheet dated 01/01/2018 revealed from 1800-2345 Resident #3 was "[redacted]." Review of the MHT note on 01/01/2018 revealed "...[redacted]..." Review of a telephone physician order dated 01/02/2018 not timed revealed "[redacted]" 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 [redacted]. Notes recorded revealed Resident #3 was "[redacted]" Review of a "Therapy Services Note" written on 01/03/2018 at 1132 revealed "[redacted]

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[redacted]..."

10. Closed medical record review on 01/09/2018 of Resident #6 revealed a [redacted] admitted to the PRTF on [redacted]/2017 due to severe behavioral problems and violence. Resident #6 was [redacted]) on [redacted]/2018. Review of the record revealed admission diagnoses included [redacted].

Review of the Q-15 Minute Observation Sheet dated 01/01/2018 revealed Resident #6 lived on the [redacted]. 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 "[redacted]" from [redacted]; and [redacted]" from [redacted] Review of the night shift notes recorded by MHT #16 revealed the resident was [redacted]". 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 [redacted]. Notes recorded the resident was [redacted]".

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V 105	Continued From page 32 [redacted]." Review of physician order dated 01/02/2018 revealed an order to place the resident on [redacted] and to be [redacted]d and [redacted]s upon return. Review of a nursing note documented by RN #1 dated 01/01/2018 at 2202 revealed resident "[redacted] Review of nursing notes documented on 01/02/2018 at 0000 recorded resident returned to facility [redacted] no apparent injuries and was placed on [redacted] 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.	V 105	*The root causes (contributing factors) of the deficiencies in systems identified, and for each:* *a)The procedure for implementing the acceptable plan of correction for the specific deficiency cited;* *b)The date by which all corrective action will be completed, and the monitoring system will be in place.* *c) The title of the person responsible for implementing the acceptable plan of correction* *d)The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.*	
V 115	.0208 (A-E) Client Services 10A NCAC 27G .0208. CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatmenthabilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described	V 115	V115 0208 (A-E) Client Services Failure of facility staff to supervise and provide a safe environment for the delivery of care to adolescent behavioral health residents. Please note that "Attachment **G**" captures the review of items that is now being accomplished as part of the morning meeting to monitor improvement in all areas needing corrective action:	

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	MHL0601258	A. BUILDING: _____ B. WING _____	01/17/2018

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V 115	Continued From page 33 in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children. This Rule is not met as evidenced by: Based on policy review, medical record review, video review, police report review, Code Purple log review and staff interview, facility staff neglected to supervise and provide a safe environment for the delivery of care to adolescent behavioral health residents for 10 of 10 sampled residents that eloped (#1, #2, #11, #7, #12, #9, #10, #8, #3, and #6). The findings included: Review on 01/09/2018 of policy title "Code Purple" last Reviewed/Revised 12/2016 revealed "Policy: To correctly identify steps to be utilized in the event of a Code Purple (psychiatric emergency) ...1. A group of RAs will be identified on each shift to be a part of the Code Purple Team ... 3. When a staff member notes that a resident is exhibiting signs of escalated behavior ... the Code Purple will be announced over the walkie-talkie with the location attached to the code ... 7. Code Purple team members will arrive at the announced location and take direction and cues from the primary staff member on the scene	V 115	**Root cause (contributing factor):** **1) Lack of a verbal hand-off process to report intake assessment information on incoming patients. Subsequently, history of patterns of elopement, history of violent behaviors, and even prior residential placement among patients was not always communicated.** (1)(a) (1) A hand-off form and formalized procedure 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 precautions shall be written on the form entitled: "High Risk/High Alert Hand-off" and must be handed to the receiving nurse for their acknowledgement and signature of same. The Unit nurse, in turn, will be responsible for implementing all orders and processes that accompany the specific precautions. Attachment "H" delineates the hand-off form and policy for its use. During daily Administrator on Call rounds, the AOC will check the 15-minute check sheets for evidence of appropriate stickers signifying patient safety precautions that must correspond with those precautions identified by the High Risk/High Alert Hand-Off and, as ordered by the patient's physician. Deficiencies noted will be immediately corrected. All intake assessment staff and nursing staff with patient care responsibilities are being trained through inservice activities on these requirements. 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.	2/18/18

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V 115	Continued From page 34 ... 9. The primary staff member on the team will work collaboratively with the RN to de-escalate the resident. 10. Based on the level of danger to self/others, the primary staff and RN will cue the Code Purple team members into position if there is a need for physical restrictive intervention. ..." Review on 01/09/2018 of the hospital's policy and procedure "Psychiatric Residential Treatment Facility" effective: 05/24/2015 revealed "... Staff (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in residential unit." Review on 01/09/2018 of policy title "Position Summary - Registered Nurse" Date Approved: 01/31/2015 revealed "...The Registered Nurse...May assume a coordinating or supervisory role with assigned licensed nursing and milieu personnel i.e. assignments, monitoring schedule/work, follow-through and high acuity direction...Effectively respond and actively participate in a psychiatric crisis to resolution...Therapeutic Milieu 2. High visibility during increased acuity and takes an active role with indicated interventions..." Review on 01/10/2018 of the facility policy titled "Elopement" reviewed/revised on 12/2016 revealed "...will maintain a safe and secure therapeutic milieu for all clients receiving inpatient treatment. Procedure: 1. In the event of an elopement, the code, 'CODE GREEN' and location will be announced over the intercom. 2. Call (Name) police department immediately. Give names of the clients. Have a description of the escaped client - name, height, weight, sex, and age. When the police arrive give a copy of the photo ID of the client from the chart. 3. The RN will immediately notify the client's physician, the	V 115	**Staff not meeting these requirements for use of the hand -off form and procedure will be addressed on a progressive disciplinary basis.** **(b) (1) Date of Completion:** 02/18/2018 **(c)(1) Responsible Person:** Director of Admissions and Referral **(d) Monitoring procedure to ensure correction** 1)(a)(1) During daily Administrator on Call rounds, the AOC will check the 15-minute check sheets for evidence of appropriate stickers signifying patient safety precautions that must correspond with those precautions identified by the High Risk/High Alert Hand-Off and, as ordered by the patient's physician. Deficiencies noted will be immediately corrected. 100% of patient admissions will be reviewed at the weekly SBC Charlotte PRTF PI Committee meeting to review for compliance with use of the "High Risk/High Alert Hand-Off form. A Governing Board Member will be a weekly participant to hear the results presented at this meeting. The findings, conclusions, recommendations, and actions 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.	

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V 115	Continued From page 35 Medical Director, the Administrator on Call, and the client's legal guardian ...6. When the resident is located, the RN will notify the physician for a determination of whether the resident is to be evaluated at the Emergency Department prior to return to the facility. 7. The client will immediately be placed on elopement precautions ... and the attending physician will be consulted for any further orders." Review on 01/10/2018 of the facility policy titled "Elopement Precautions" reviewed/revised 12/2016 revealed "... Residents who talk of running away, participate with or know of a planned runaway or actually run away will be placed on elopement precautions ...Procedure ...2. The adolescent who returns from an elopement must write a detailed narrative describing the events prior to the run, the run itself, and what transpired while the resident was away. This narrative must complete prior to the client being removed from elopement precautions. The narrative should include an effort to discover an alternative manner of coping, other than running away. 3. Adolescents on elopement precautions will have a bedtime of 8:30 pm every night. 4. Adolescents will be provided foam slippers to use as footwear. No shoes will be permitted. 5. Residents will not be allowed to leave the unit. 6. The individual's treatment plan will be modified to reflect the interventions necessary to maintain safety, i.e. room search daily, limited phone calls. 7. A physician's order will be required to remove the resident from elopement precautions. 8. Criteria for advancement from elopement precautions include: no dangerous behavior to self or others, no sneaky or suspicious behavior, compliance with rules/medications, the willingness to talk with staff regularly about concerns/feelings."	V 115	1) (a)(2) A patient safety notification system has been developed whereby all patients on the PRTF are having identification stickers that are color- coded with level of precautions placed on their 15-minute round sheets. According to this system, based on their identified safety need, patients will have a red, yellow, green, or white level of precaution assigned. For example, patients on elopement precautions will be identified on their 15-minute check sheet as such and staff must ensure that they adhere to all provisions of the Elopement policy including restriction on outdoor activities, as ordered by the patient's physician. Attachment "I" delineates the new process for patient safety notification. During daily Administrator on Call rounds, the AOC will check the 15-minute check sheets for evidence of appropriate stickers signifying patient safety precautions that must correspond with those precautions identified by the High Risk/High Alert Hand-Off and, as ordered by the patient's physician. Deficiencies noted will be immediately corrected. Staff not meeting these requirements will be addressed on a progressive disciplinary basis. All intake assessment staff and nursing staff with patient care responsibilities are being trained through inservice activities on these requirements. 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. Staff not meeting these requirements for use of the sticker system procedure will be addressed on a progressive disciplinary basis. **(b) (1) Date of Completion**: 02/18/2018 **(c) (2) Responsible Person**: Director of Nursing	2/18/18

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V 115	Continued From page 36	V 115	**(d) Monitoring procedure to ensure correction**	

Review on 01/11/2018 of the facility policy titled "Admission Procedures" reviewed/revised 12/2016 revealed " ...B. Belongings are to be itemized on the belonging list when brought to the unit ...C. Patient may keep at bedside a 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 location ...5. 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 documentation will facilitate the recording of accurate, timely data, which reflects the current status of the client, the care provided, and he progress made by the client. Procedure ...2. 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 Nurse will document ...summary documentation will be completed every seven days ...incident charting will be completed. The weekly/ daily nursing notes will include the individual response to meds, any side effects and relevant lab values. 4. Incident charting includes any circumstances involving the client, which indicate an immediate or unexpected change of status. Some examples include ...injuries, special treatment procedures ...

1) (a)(2) During daily Administrator on Call rounds, the AOC will check the 15-minute check sheets for evidence of appropriate stickers signifying patient safety precautions that must correspond with those precautions identified by the High Risk/High Alert Hand-Off and, as ordered by the patient's physician. Deficiencies noted will be immediately corrected. The findings will be summarized at the Hospital's Morning Meeting of leadership staff. The findings will be aggregated and reviewed at the weekly PRTF PI Committee. A Governing Board Member will be a weekly participant to hear the results presented at this meeting. The findings, conclusions, recommendations, and actions 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.

Root cause (contributing factor):
2) The treatment plans did not always reflect individualized patient information including elopement history, violence history, and strategies to prevent. A treatment plan audit for same was not in place to identify deficient entries.

2)(a)(1) All staff with responsibility for completion of the treatment plan are being instructed on the requirement to include all patient information that will be necessary to formulate an effective treatment plan for the resident. Information shall include elopement and violence history, suicide precautions, and any precautions that may impact the resident's safety and the safety of other residents and staff.

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V 115	Continued From page 37 and self-abusive behaviors. 5. Summary documentation is directed at recording progress toward achieving the measurable treatment plan goal. Summary documentation should include ...Client's mental status, physical status, behavior in the therapeutic milieu, mood, affect, medication compliance and response, appetite and intake, percent of weight gain or loss, grooming and hygiene, quality of sleep, nursing interventions, current nursing care being provided, and any restrictive interventions needed ...7. Staff will document the client's location on the observation sheet every 15 minutes ..." Review of a local "Police Department Incident Report" revealed the police were called on 01/01/2018 at 2156 to assist with an assault to MHT #10, property damage and ten missing persons listed as Resident #8 ([redacted] Resident #9 ([redacted] Resident #10 ([redacted] Resident #2 ([redacted] Resident #1 ([redacted] Resident #6 ([redacted] Resident #11 ([redacted] Resident #12 ([redacted] Resident #3 ([redacted] and Resident #7 ([redacted] A.1. Open medical record review on 01/09/2018 for Resident #1 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) on [redacted]/2017 with diagnoses of [redacted] Review of the intake assessment revealed the resident had a [redacted] Admission vital signs were [redacted] Review of the Psychiatrist Evaluation documented on [redacted]/2017 at 2050 revealed "..[redacted]	V 115	All staff with responsibility for the completion of the treatment plan are being trained through inservice activities on these requirements. 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. Staff not meeting these requirements for individualization of the treatment plan with these patient precautions 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 Leadership meeting (see monitoring section for description). Deficiencies noted will be updated within one hour of discovery. Staff not meeting these requirements will be addressed on a progressive disciplinary basis. **(b)(1) Date of Completion:** 02/18/2018 **(c)(1) Responsible Person:** Director of Clinical Services 2) (a)(2) All staff with responsibility for completion of the treatment plan 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 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. All staff with responsibilities for treatment plans are being trained through inservice activities on these requirements. In order to remain on the schedule, staff not in attendance for the inservice are required	2/18/18

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V 115	Continued From page 38	V 115		

[redacted]

Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #1 had the following risk and history of violence: "[redacted] 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 the medical record revealed documentation of a [redacted] for Resident #1 on [redacted]/2017 from [redacted] for [redacted], a [redacted] on [redacted]/2017 from [redacted]8 for [redacted], a [redacted] on [redacted]/2017 from [redacted]5 for [redacted], and a [redacted] on [redacted]/2017 [redacted] for [redacted] Review of facility video recordings on 01/10/2018 of residential hallways on 01/1/2018, revealed Resident #1, fully dressed in street clothes to include [redacted]

Review of the record revealed a nursing shift note dated 01/01/2018 at 2035 that recorded [redacted]

to receive training on this requirement prior to any scheduled work by the completion date.

Staff not meeting these requirements for use of the treatment plan to update with patient precautions 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 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.

(b)(2) Date of Completion: 02/18/2018

(c) (2) Responsible Person: Director of Clinical Services

(d) Monitoring procedure to ensure correction
2)
(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 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 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 Leadership Staff, Monday through Friday.

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V 115	Continued From page 39 [redacted] Record review revealed a 7pm-7am nursing note dated 01/01/2018 at 2100 that recorded "[redacted]." Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room [redacted] on 01/01/2018. 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 "[redacted] through 2130, at 30. Other: [redacted] Review of the Observation Sheet dated 01/02/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at "[redacted] Review of the night shift notes recorded by MHT #16 revealed the resident was "[redacted]	V 115	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 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-assessments not documented, as required. Similarly, the performance improvement review process was not capturing the review for compliance with items** a) In response: All SBC Charlotte Hospital leadership staff with responsibilities within their departments for medical record documentation are being re-educated through meetings and written memoranda on the specific requirements for the medical record components including: but not limited to: (1) Dating/timing of orders within requirements (2) Frequency of documentation (3) Medications documented as ordered (4) Completion of assessments and reassessments per time requirements (5) Frequency of MD Progress Notes (6) Co-signature by MD after Seclusion and Restraint within 24 hours These items are in addition to those otherwise noted in this report. All SBC Charlotte Hospital and Medical staff with responsibility for documentation are being re-educated through meetings and written memoranda of the requirements for documentation, as delineated above.	2/18/18

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V 115	Continued From page 40 [redacted]." Review of the medical record on 01/09/2018 revealed no documentation of a nursing assessment in the record after the resident was returned from elopement. Review of the record 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 [redacted]. Note recorded that [redacted] were "[redacted]." Review of nursing note dated 01/02/2018 at 1430 revealed "[redacted])." Review of telephone orders dated 01/02/2018 not timed revealed orders to place Resident #1 on [redacted]s for [redacted]y and [redacted], [redacted] and [redacted] upon return to facility. Review of physician orders dated 01/02/2018 at 2050 revealed a telephone order for [redacted] (medication for behavior) [redacted] as needed for [redacted]. Review of a Case Management Note documented by the Director of Clinical Services (DCS), dated 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 [redacted]. Note recorded the DCS and the DON questioned client about any injuries, pain or other concerns.	V 115	All SBC Charlotte Hospital leadership staff with responsibilities within their departments for medical record documentation have been re-educated on the medical record audit process and associated expectations for its completion. 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. **(b) Completion Date:** Re-education of Hospital and Medical Staff: 02/18/2018 Re-education of Hospital leaders on requirements: 01/31/2018 Initiation of intensified audits: 02/01/2018 **(c) Responsible Person:** Director of Compliance/Quality/Risk **(d) Monitoring procedure to ensure correction 3)** a) A 100% audit of medical records will occur over the course of the week against medical records including compliance with: (1) Dating/timing of all orders (2)) Frequency of documentation (3) Medications documented as ordered (4) Completion of assessments and reassessments per time requirements (5) Frequency of MD Progress Notes (6) Co-signature by MD after Seclusion and Restraint within 24 hours	

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V 115	Continued From page 41 Note recorded the DCS set expectations for resident's return to the unit. Note recorded the client was assessed by a Registered Nurse (RN). Review of the Psychiatrist progress note dated 01/04/2018 at 1237 revealed "[redacted]" Review of a Health Incident Review Report for Resident #1 completed by RN #2 and dated 01/01/2018 recorded "[redacted]." Review of the report revealed the date and time of the elopement was 01/01/2018 at 2155. Review of a Health Incident Review Report for Resident #1 completed by RN #4 on 01/02/2018 recorded "[redacted]"	V 115	The findings of this audit will be reported on, at least, a weekly basis at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date. **4) Root cause (contributing factor):** **Transition between units sharing mutual space was not consistently being assessed before moving patients from one area to another. This was attributed to the windows being frosted to prevent patients from viewing one another on opposing units.** All Hospital Staff with patient care responsibilities are being inserviced to look through the window before moving from one unit to another and to not open the door if, in doing so, patients can spill over 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 unit. 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. 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.	1/10/18 Frosting removed 2/18/18 Staff trng in all elements completed

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	MHL0601258	A. BUILDING: _____ B. WING _____	01/17/2018

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V 115	Continued From page 42 [redacted]" Review of a Health Incident Review Report for Resident #1 completed by RN #5 and dated 01/02/2018 recorded "([redacted] Review of the report revealed the date and time of the incident was 01/02/2018 at 1321. Review of the Medication Administration Record revealed no available documentation of [redacted] administered on 01/02/2018. Review of Restrictive Intervention documentation dated 01/02/2018 at 1321 revealed a physician order for [redacted] for [redacted]. Restrictive intervention documentation revealed Resident #1 was placed in a [redacted] on 01/02/2018 at [redacted], then a [redacted] at [redacted] and [redacted] at [redacted]2. Restrictive Intervention documentation revealed Resident #1 was administered [redacted] at [redacted] Interview on 01/12/2018 at 1015 with RN #5 revealed Resident #1 was the last resident escorted to [redacted] room at 0[redacted]. Resident #1 had a [redacted] Interview on 01/12/2018 at 1015 with RN #5 revealed Resident #1 was admitted to the [redacted]	V 115	This expectation has been incorporated into the Hospital's orientation. Compliance with the process is being evaluated with all patient events and as a part of daily monitoring for compliance with expectations whereby camera 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. **(b) Date of Completion:** Frosting removed from windows: 1/10/18 Education on expectations related to looking through the doorways before entering a patient unit: 02/18/2018 "Own the door" campaign training completed: 02/18/2018 Camera review process in place as of: 02/18/2018 Content on safety expectations in place in orientation as of: 02/18/2018 **(c) Responsible Person:** Safety Officer **(d) Monitoring procedure to ensure correction** 4) On a daily basis, during the Safety meetings, the doorways of all PRTF nursing units will be reviewed per camera on a Monday through Friday basis with the results of Friday, Saturday, and Sunday incorporated into Monday's report) to assess if staff are looking through the windows before entering patient units. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday.	

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V 115	Continued From page 43 hall due to elopement risk. Interview revealed we [redacted] Interview revealed we [redacted] 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 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) on [redacted]/2017 as [redacted] Review of the record revealed admission diagnosis included [redacted] Review of admissions information titled "Clinical Evaluation/Diagnostic Assessment" dated [redacted]/2017 recorded by [redacted] revealed [redacted] Review revealed the resident [redacted] Review revealed on [redacted]/2017 the resident [redacted]. The resident was [redacted]. Review of a Comprehensive Psychosocial Assessment Tool documented by [redacted] on [redacted]/2017 (not timed) recorded the resident [redacted]."	V 115	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 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):** **5)False perception by staff that the police could not be called to assist when staff was not, otherwise, able to obtain control of the residents.** (a) All Hospital staff are now receiving training through inservice education specific to the 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 have to have approval by any off site administrative staff to do so (as previously noted in Attachment "E"). 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. 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.	01/ 17 /2018 Meeting with police 02/18 /2018 Completion on trng on policy

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V 115	Continued From page 44 Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #2 had the following risk and history of violence: "[redacted] 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 #2, fully dressed in [redacted] Review of admission orders dated 12/19/2017 revealed the resident was placed on assault precautions with every 15 minute observation checks. Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room [redacted] on 01/01/2018. 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 "[redacted]" (location not defined) from [redacted] (location not defined). Review of the night shift notes recorded by MHT #14 revealed the resident was returned from elopement and placed on every 15 minute room checks. The notes recorded that the resident was given [redacted] and [redacted]. Review of nursing notes documented by RN #2 on 01/01/2018 at 1920 recorded the resident's [redacted] and [redacted] was given [redacted]. Notes recorded "[redacted]	V 115	100% of key events including restrictive interventions, aggressive acts of patients to patients 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 Police Dept. will occur. Staff not meeting these requirements after re-training will be addressed on a progressive disciplinary basis. **(b) Date of Completion:** Meeting with Charlotte Police Dept.: 01/ 17 /2018 Completion of training on policy: 02/18 /2018 **(c) Responsible Person**: Director of Quality/Compliance/Risk **(d) Monitoring procedure to ensure correction** 5) Compliance will be monitored as follows: A 100% review of key events including restrictive interventions, aggressive acts of patients to patients 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 contacted, when indicated. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 at each of their respective meetings.	

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V 115	Continued From page 45	V 115	**Root cause (contributing factor):**	2/18/18

[redacted]." 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 the resident returned to the facility [redacted]. Notes recorded the resident was [redacted]." Record review revealed the resident was [redacted] and dressed in [redacted] upon return to the facility on 01/02/2018. Review revealed the resident was placed on [redacted]s upon return. Review of nursing notes documented on 01/02/2018 at 1400 recorded [redacted]." Review of a psychiatrist progress note dated 01/04/2018 at 1242 recorded the patient admitted to [redacted], stating tha[redacted] Review of the notes revealed [redacted] ..."

Review of Health Incident Review Report for

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 training that an indication of an impending elopement is that sometimes the resident is wearing multiple layers of clothes or dresses in sneakers or shoes when they normally do not do so.

(c)Staff have been inserviced through classroom and written memoranda on their need to query residents 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 same.

(b)Date of Completion:
Policy change implemented 02/18/.2018

Monitoring for compliance:
02/18/2018

(c) Responsible person:
Director of Nursing

(d)Monitoring procedure to ensure correction

6) Compliance will be monitored as follows:
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 multiple layers of clothing. In addition, as part of 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

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V 115	Continued From page 46 Resident #2 completed by RN #2 and dated 01/01/2018 recorded "[redacted]." Review of the report revealed the date and time of the elopement was 01/01/2018 at 2155. Interview on 01/12/2018 at 1015 with RN #5 revealed Resident #1 was admitted to the [redacted] hall due to elopement risk. Interview revealed we [redacted] Interview revealed we [redacted] 7. Resident #1 said they had [redacted] Interview revealed from that point forward Resident #1 and Resident #2 were not to be on the same hall together. 3. Open medical record review of Resident #11 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted] Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #11 had the following risk and history of violence: "[redacted]." 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	V 115	clothing of patients. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 at each of their respective meetings **Root cause (contributing factor):** **7) Staff verbalized sometimes feeling "ill equipped" 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 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 contact and utilize the police department if a patient event escalates to one that cannot be otherwise handled by the staff on duty. 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. 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 that are standardly being asked include the following that are adapted from the Studer model: (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.	

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V 115	Continued From page 47 facility video recordings on 01/10/2018 of residential hallways on 01/1/2018, revealed Resident #11, fully dressed in [redacted] 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 dated 01/01/2018 revealed the resident was assigned to Room [redacted] 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 "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted] 5. Review of Night shift notes recorded by MHT #17 revealed [redacted]." Review of notes at 2202 revealed "[redacted]." A nursing note by RN #1 on 01/02/2018 at 0000 recorded "[redacted]." Nursing notes documented by RN #5 dated	V 115	(3)Is there anyone that you want to recognize today as a team member that has been especially helpful 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? Three evidence-based programs have been identified to assist staff in gaining more effective skills in working with patients in the PRTF 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-collaborative-problem-solving-approach/). The second tool is from **Advanced Trauma Solutions** (advanced trauma.com). The last tool is the CARE program model that is supported by UNC Charlotte and Duke. All programs utilize a trauma-informed care approach but do not use a level system. **b) Date of completion**: Implementation of new patient care model 03/31/2018 Implementation of rounding using Studer Model tool: 02/16/2018 **c) Responsible person:** Chief Executive Officer **d)Monitoring procedure to ensure correction** 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? (2) Do you have the right amount of people to do your job effectively? If not, describe.	2/16/18 Revised rounds model in place 3/31/18 New care model

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V 115	Continued From page 48 01/02/2018 at 1330 recorded "[redacted]." Notes at 2200 recorded the resident was transported to a [redacted] for evaluation and returned from [redacted] on 01/03/2018 at [redacted]. Notes revealed the resident had [redacted] and [redacted]. Notes revealed [redacted] medication was administered. Review of an LPN note dated 01/02/2018 at 0050 recorded "[redacted]." Review of the medical record on 01/10/2018 revealed no further documentation of a nursing assessment in the record after return from elopement on 01/01/2018. Review on 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded "([redacted]." Review of a psychiatrist note recorded on 01/04/2018 at 1112 revealed "...[redacted].	V 115	(3) Is there anyone that you want to recognize today as a team member that has been especially helpful 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? These rounds will occur daily (weekends covered by AOC). The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 at each of their respective meetings. **Root cause (contributing factor):** **8) Perception of staff of being "short staffed" on some shifts** 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 involvement, history of substance abuse disorder, and history of a conflict or affiliate relationship with a current resident of SBC Charlotte. 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,	1/5/18 Staffing analysis as part of RCA review 2/16/18 Studer rounds model in place

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V 115	Continued From page 49	V 115	as appropriate to reduce their discomfort are being employed. Examples include calling in a PRN staff member or reallocating staff to the area where there is a perception of "short staffing".	

[redacted] ..."

4. Closed medical record review of Resident #7 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted]

Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #7 had the following risk and history of violence: "[redacted]." 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 #7, fully dressed in [redacted]

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 dated 01/01/2018 revealed the resident was assigned to Room [redacted] 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 "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted] through [redacted] then "[redacted]

A daily review of staffing coverage for all shifts is now being reported to the Hospital's Morning Meeting of Leadership staff. Shifts out of compliance with staffing are addressed through PRN coverage or leadership assisting with any deficits in same.

Whenever there is a patient event requiring a root cause analysis, the adequacy of staffing and competencies and qualifications of staff are assessed to determine if staffing might have been a factor in the occurrence or prevention of same.

(b) Date of implementation of all elements:

Rounds by CEO using Studer model: 02/16/2018
Daily review of staffing coverage and inclusion of staffing as a part of RCA discussion: 01/ 05/2018

(c) Responsible person:
Director of Nursing

(d)Monitoring procedure to ensure correction

8) Staff's perceptions about being short-staffed are being monitored as follows:
As part of the daily rounds made by the CEO, staff will be asked to answer the following questions:
"Do you have the right amount of people to do your job effectively? If not, describe."
These rounds will occur daily (evenings and weekends covered by AOC).

On a daily basis, the Director of Nursing is reporting on compliance with staffing requirements for all nursing

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V 115	Continued From page 50	V 115	units. The findings from these activities are being reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday.	

[redacted]" from [redacted]; then "[redacted]" from [redacted]. Review of Night shift notes recorded by MHT #13 revealed "[redacted]..." Review of nursing notes documented by RN #1 dated 01/01/2018 at 2015 revealed the resident was [redacted] and offered and refused prn (as needed) medication fo[redacted]. Review of notes at 2202 revealed "[redacted]." A nursing note by RN #1 on 01/02/2018 at 0000 recorded "[redacted]." Review of nursing notes documented by an LPN dated 01/02/2018 at 0130 recorded "[redacted]." Nursing noted "[redacted]." Nursing notes documented by RN #5 dated 01/02/2018 at 1300 recorded "[redacted]." Notes at 2200 recorded the resident was transported to [redacted] for evaluation and returned from [redacted] on 01/03/2018 at 0645. Notes revealed the resident had [redacted]

The findings of compliance with staffing grids and 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 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. In addition to the above, The findings from all Root Cause analyses 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 staff. Specific reference is made to walkie talkies and batteries for same. 1/15/18

(a)Walkie talkies were obtained whereby there is now one available for all patient care staff including 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 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.

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 that are standardly being asked include the following that are adapted from the Studer model: "Do you have the right tools that you need to do your job today effectively? If not, what is needed?

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	MHL0601258	A. BUILDING: _____ B. WING _____	01/17/2018

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STRATEGIC BEHAVIORAL CENTER-CHARLOTTE	1715 SHARON ROAD WEST 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	Continued From page 51 [redacted]. Notes revealed [redacted] was administered. 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 "[redacted]." Record review revealed the resident was discharged on [redacted]/2018. 5. Open medical record review of Resident #12 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted] Review of a Comprehensive Psychosocial Assessment Tool completed by [redacted] on [redacted]/2017 at 1703 revealed the patient had a [redacted]." 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 [redacted]. 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	V 115	**(b) Date of completion:** Purchase of walkie talkies and placement of batteries in medication rooms: 01/ 15/2018 Implementation of rounding question: 02/16/2018 **(c) Responsible person:** Milieu Manager **(d) Monitoring procedure to ensure correction** 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 areas. Staff's perceptions on supply and equipment availability are being monitored as follows: 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.	

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V 115	Continued From page 52 dated 01/01/2018 revealed the resident was assigned to Room [redacted] 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 "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" Review of Night shift notes recorded by MHT #16 revealed "[redacted]..." 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 and stated it was not accurate. The nurse stated it was documented that the resident was in the [redacted] at 2300, but [redacted] didn't return until 0000. "She couldn't have laid eyes on the resident [redacted] wasn't back yet. I don't know why she documented that. It isn't correct."	V 115	**Root cause (contributing factor):** **10) Perception by staff that there has been no change (at date of survey) to address incidents and re-training on gears/de-escalation.** (a) Changes made to the SBC Charlotte environment will be compiled and posted in employee areas so that staff are aware of same. The CEO will conduct roundtables with staff to learn more about their perceptions on changes made to address incidents and re-training on gears/de-escalation. An electronic safety survey has been deployed for use at the facility. Staff will have the ability to complete the survey electronically or by hard copy. 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 the survey will be used to improve on systems or promotion of same. The survey will be repeated in three and six months to review for evidence of progress made. **(b) Date of completion of all elements:** 02/28/2018 **(c) Responsible person:** Human Resources Director **(d)Monitoring procedure to ensure correction** 10) The results from the survey will be compiled to assess for evidence in improvement of results. The findings of this will be aggregated and presented 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 pursuant to the safety survey's 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.	2/28/18

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V 115	Continued From page 53 6. Open medical review on 01/11/2018 of Resident #9 revealed a [redacted] admitted to the PRTF unit on [redacted]/2017 due to [redacted]. Review of the Intake Assessment dated 11/06/2017 revealed Resident #9 was at risk for elopement with a history of "[redacted]." 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 [redacted]. Review revealed Resident #9 lived on the [redacted] hall. Review of a nursing note dated 01/01/2018 at 2120 revealed Resident #9 "[redacted]. 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 [redacted] was "[redacted]." Review revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded "([redacted]	V 115	**Root cause (contributing factor):** **11) Administrator On Call (AOC) phone number not readily available to staff** (a) The AOC on-call number is now posted with the nursing schedule in employee-only areas. Additionally, the schedule is posted with the Nursing staffing book. **(b) Date of completion:** 02/13/2018 **(c) Responsible person:** Human Resources Director **(d)Monitoring procedure to ensure correction** 11) As part of the daily rounds made by the CEO and Leadership team, the staffing sheet will be assessed to ensure that it has the current name/contact number of the AOC. 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. 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 at each of their respective meetings. **Root cause (contributing factor):** **12) One nursing station was used for medication passes of all units and, as a result, created a risk of inadvertently mixing patient groups.** (a) The use of the one medication room for medication dispensing was discontinued and staff prohibited from utilizing this system (see Attachment G for medication administration clarification).	2/13/18 2/2/18 Med room 2/18/18 Med audits

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V 115	Continued From page 54	V 115		

[redacted]". Review of a physician order dated 01/02/2018 revealed Resident #9 was placed on [redacted]. 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 "[redacted]" Review revealed Resident #9 stated "[redacted]."

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 [redacted] along with other peers.

7. Open medical record review on 01/10/2018 for Resident #10 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) from [redacted] on [redacted]/2017 with a diagnosis of [redacted] Review of the nursing notes revealed Resident #10 arrived on the PRTF unit at [redacted]. Review of nursing notes revealed the resident was [redacted], with no complaints of pain or discomfort. Review of the nursing notes revealed the resident had old injuries noted to [redacted]. Admission vital signs were [redacted]. Review

Nursing staff were instructed to dispense medications on their individual nursing units.

This process and associated expectations has been incorporated into the Hospital's Nursing orientation.

(b) Date of completion:
Discontinuation of the central medication station for medication administration: 02/02/2018
Implementation of the medication audit system described: 02/18/2018

(c) Responsible person: Director of Nursing

(d)Monitoring procedure to ensure correction
12) On a weekly basis, the Director of Nursing or trained delegate will observe a medication pass on every shift to assess if the requirements related to medication administration are being followed including restriction to medication administration confined to each patient's own unit. The findings of this review 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.

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V 115	Continued From page 55 of the intake assessment revealed the resident was currently [redacted]. Further review of the intake assessment revealed documentation of elopement risk related to [redacted]. Further review of the "Admission Intake Assessment Form" dated 12/22/2017 stated Resident #10 had the following risk and history of violence: "[redacted]." 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 [redacted] Review of the record revealed a nursing note documented by RN #1 dated 01/01/2018 at 2045 that recorded "[redacted]." Review of the record revealed a note documented by RN #1 dated 01/01/2018 at 2202 that recorded "[redacted]." Review of the record revealed a note documented by RN #1 dated 01/02/2018 at 0000 that recorded "[redacted]." Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room [redacted] on 01/01/2018. Review of the Observation Sheet dated 01/01/2018	V 115	**Root cause (contributing factor):** **13)Process for accessing police was not clear to staff** (a) All Hospital staff are receiving training specific to the 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 have to have approval by any off site administrative staff to do so. 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. 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. 100% of key events including restrictive interventions, aggressive acts of patients to patients 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 Police Dept. will occur. Staff not meeting these requirements after re-training will be addressed on a progressive disciplinary basis. **(b) Date of Completion:** Meeting with Charlotte Police Dept.: 01/17/2018 Completion of training on policy: 02/18/2018 **(c) Responsible Person:** Director Quality/Compliance/Risk	1/ 17 /18 Meeting with Police 2/18/18 Completion of training on policy

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V 115	Continued From page 56 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at "[redacted] 1930, at [redacted] from [redacted], at [redacted] at [redacted], at [redacted] from 2130 through [redacted]. [redacted] from [redacted]. Review of the Observation Sheet dated 01/02/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at "[redacted] from [redacted]. Review of the night shift notes recorded by MHT #16 revealed the resident "[redacted]" 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 0010 that recorded the resident returned to the facility [redacted]. Note recorded the resident was "[redacted]" Note recorded that [redacted] were "[redacted]." Review of telephone orders dated 01/02/2018 not timed revealed orders to place Resident #10 on [redacted] for [redacted]y and [redacted], [redacted]h and [redacted] upon return to facility. Review of a Case Management Note documented by the Director of Clinical Services (DCS), dated 01/02/2018 and signed as "Late Entry" on 01/03/2018 not timed revealed she met with the client, the Director of	V 115	**(d) Monitoring procedure to ensure correction** 13) Compliance with staff contacting the Police, as instructed per policy will be monitored as follows: A 100% review of key events including restrictive interventions, aggressive acts of patients to patients 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 contacted, when indicated. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 at each of their respective meetings. **Root cause (contributing factor):** **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 residents/staff.** a) A memorandum is being prepared and distributed to all staff to alert them of the need to communicate any identified doors or furniture that could pose a safety hazard for residents/staff.	2/18/18

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Nursing (DON) and the Milieu Manager (MM) after the resident was returned to the facility [redacted]. Note recorded the DCS and the DON questioned client about any injuries, pain or other concerns. Note recorded the DCS set expectations for resident's return to the unit. Note recorded the client was assessed by a Registered Nurse (RN). Review of the Psychiatrist progress note dated 01/04/2018 at 1249 revealed "[redacted]."

Review of a Health Incident Review Report for Resident #10 completed by RN #1 and dated 01/01/2018 recorded "[redacted]." Review of the report revealed the date and time of the elopement was 01/01/2018 at 2155.

8. Open medical record review of Resident #8 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted] Review of a Comprehensive Psychosocial Assessment Tool completed by [redacted] on [redacted]/2017 at 1000 revealed the patient stated, "[redacted]." 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.

b) Date of completion: 02/18/2018

(c) Responsible person:
Director of EOC

(d)Monitoring procedure to ensure correction
14) During the daily EOC rounds, the EOC Director will assess for evidence of doors or furniture that, if compromised or malfunctioning, could pose a safety hazard for residents/staff. The item will be taken out of service or removed from the area, as appropriate. The EOC Director will assess for evidence of 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, 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.

Root cause (contributing factor):
15) Doors being left open by staff at night were not secured between units, thus increasing risk of patients intermixing inappropriately. 2/18/18

a) A follow-up memorandum is being prepared and distributed to all staff to alert them that they are not to leave the doors open between units as this compromises the security of these units.

b) Date of completion: 02/18/2018

c) Responsible person:
Director of EOC

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V 115	Continued From page 58 Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room [redacted] 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 "[redacted]" at [redacted]; then "[redacted] from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" at [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted]. Review of Night shift notes recorded by MHT #13 revealed "[redacted]." Review of nursing notes documented by RN #1 dated 01/01/2018 at 2030 revealed the resident was involved in [redacted] and [redacted]. Review of notes at 2202 revealed "[redacted]." A nursing note by RN #1 on 01/02/2018 at 0000 recorded "[redacted]." Review of the medical record on 01/10/2018 revealed no documentation of a nursing assessment in the record. Review	V 115	**(d) Monitoring procedure to ensure correction** 15)Compliance with keeping the unit doors closed will be monitored by the AOC on a daily basis through camera means. 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, 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. **Root cause (contributing factor):** **16) S&R policy and procedure not consistently followed per requirements)** All nursing staff with responsibility for seclusion or restraint requirements are being apprised through inservice activity of the requirements specific to the associated policy and procedure. . 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. The policy and procedure for Seclusion and Restraint has been reviewed with the Medical Staff to ensure their compliance with the associated requirements. **b) Date of completion:** 02/18/2018 **c) Responsible person:** Director of Quality/Compliance/Risk	2/18/18

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V 115	Continued From page 59	V 115	**(d) Monitoring procedure to ensure correction**	

on 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded [redacted]." Review of a psychiatrist note dated 01/06/2018 at 1054 revealed "[redacted]"

Review of a Health Incident Review Report for Resident #8 dated 01/01/2018 at 2155 revealed "[redacted]..."

9. Closed medical record review of Patient #3 on 01/09/2018 revealed a [redacted] admitted to the PRTF on [redacted]/2017 as a [redacted] Review of the record revealed the admission diagnosis was [redacted] Review of a nursing note dated 01/01/2018 timed at 1031 revealed a blank "Nursing Shift Note." Review of a restrictive intervention on 01/01/2018 from 2002 to 2008 revealed Resident #3 was placed in a [redacted] from 2002 to 2008 because [redacted]." Review of a nursing note (not dated) and timed at 2145 revealed "[redacted]

16) 100% of episodes of Seclusion and Restraint will be monitored for compliance with requirements in accordance with the policy and procedure.

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.
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 at each of their respective meetings.

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[redacted]." Review of the Observation Sheet dated 01/01/2018 revealed from 1800-2345 Resident #3 was "[redacted]" Review of the MHT note on 01/01/2018 revealed "...[redacted]..." Review of a telephone physician order dated 01/02/2018 not timed revealed "[redacted]..." 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 [redacted]. Notes recorded revealed Resident #3 was "[redacted]." Review of a "Therapy Services Note" written on 01/03/2018 at 1132 revealed "[redacted]

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[redacted] ..."

10. Closed medical record review on 01/09/2018 of Resident #6 revealed a [redacted] admitted to the PRTF on [redacted]/2017 due to severe behavioral problems and violence. Resident #6 was [redacted]) or [redacted]/2018. Review of the record revealed admission diagnoses included [redacted].

Review of the Q-15 Minute Observation Sheet dated 01/01/2018 revealed Resident #6 lived on the [redacted]. 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 "[redacted] from [redacted] ; and "[redacted]" from [redacted] 5. Review of the night shift notes recorded by MHT #16 revealed the resident was [redacted] ". 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 [redacted]. Notes recorded the resident was [redacted] ." Review of physician order dated 01/02/2018 revealed an order to place the

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resident on [redacted] and [redacted] and [redacted] upon return. Review of a nursing note documented by RN #1 dated 01/01/2018 at 2202 revealed resident "[redacted]. Review of nursing notes documented on 01/02/2018 at 0000 recorded resident returned to facility [redacted], no apparent injuries and was placed on [redacted]

Interview on 01/11/2018 at 1605 with AS #25 revealed she had no process to report intake assessment information with resident risk and violence history to the staff on the PRTF units. Interview revealed the intake assessments are placed in the medical record and available for staff to read/review. Interview revealed she completes a data sheet with the risk factors and triggers on the shared drive. Interview revealed the share drive was only available to the heads of each department. Interview confirmed the shared drive is not available to unit staff. Interview revealed she sends the data sheet information to the DON to report to nursing staff on the unit.

Interview on 01/17/2018 at 1510 with AS #25 revealed she does have an admission process. "The admissions office receives a referral from the outside provider, (Name) facility or guardian and sends via email to the Director of Clinical Services (DCS), CEO, Medical Director and DON. They review the referral and communicate feedback through email. The DCS & Medical Director notifies me if the referral is approved and if referral is denied they send reason for denial. I notify the outside provider of clinical approval, get insurance approval, get document from referral

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provider and submit MCO-Insurance. I then notify the provider, facility or guardian and schedule them to come in for admission. I send the treatment plan, crisis plan, data sheet and referral to heads of each department (head of milieu, CEO, Education, Therapy, DCS and DON) a day in advance. No one comes in on weekends. Very rare for weekend admission. Send consent prior to admission or get signed on admission if guardian is present. Meet with admission staff (admission assessor) weekend admissions. Complete intake assessment and enter information into computer. Notify staff of admission times. The MD and therapist see within the first 24 hours." Interview revealed she is now sending risk factors via email to the DON, DCS, CEO and other department heads and highlighting the risk factors within the email.

Interview on 01/12/2018 at 1015 with RN #5 revealed she receives the intake information via email. She stated that if she is not in the facility, she passes the information from the intake assessment on the next day. Interview revealed the nurse on the unit received the information that admissions places in the medical record and he/she is responsible for reading and reviewing the history and admission packet.

Interview on 01/10/2018 at 1625 with AS #21 revealed the placement of residents on the 200 hall are decided based on advanced programming. Interview revealed the boys and girls are placed in separate rooms, ideally splitting the hall with the boys on one side and the girls on the opposite side. Interview revealed gender, ages and level of functioning plays a part in how residents are assigned on the 200 hall.

Interview on 01/11/2018 at 1726 with RN #5

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revealed we try to make 200 hall the "privileged hall." We try to put all new admits on 200 hall for first 48 hours or so, dependent on their history. Interview revealed the girls typically go to the [redacted] hall and the boys go to the [redacted] hall. If there is no bed available, we may admit to 200 hall. If they present frightened or crying, we will place on 200 hall.

Review of facility video on 01/10/2018 of resident halls 01/01/2018 revealed the following:
300 Hall
2133 MM #8 unlocked the 300/200 door to enter 200 hall from 300 hall ([redacted]). Resident [redacted] ([redacted]), Resident [redacted] ([redacted]) and Resident [redacted] ([redacted]) push through the 200 hall to enter the 300 [redacted].
Residents [redacted] and other unknown residents began throwing a trash can, tearing up paper, tearing schedules off the wall, going in and out of resident rooms. Other residents began to crowd around the door to room 306.
2140 Resident [redacted] punched MHT #10. Resident [redacted] swung at MHT #10 again. MHT #10 attempted to place Resident [redacted] in a hold. Other staff were watching, and offered no assistance. Resident [redacted], Resident [redacted] and Resident [redacted] followed MHT #10 down the hall. Resident [redacted] picked up MHT #10 from the waist from behind and tossed him forward onto his feet. He fell into the residents and staff standing at the 300 doc station locked door (door exiting the unit). The residents went back to the other end of the hall.
2142 MM #8 walked back toward Resident #1 at 200/300 unit door. As MM #8 was walking, Resident [redacted] spit in MHT #10's face. Resident [redacted] picked up MHT #10's walkie talkie (in pieces) and the residents were throwing it on the floor and stomping it.
2143 Resident [redacted] walked to [redacted] room and put on

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a coat, gloves, shoes and a hat. Resident [redacted] and Resident [redacted] spit at MM #8 as he was walking down the hallway.
2145 Resident [redacted] gave Resident [redacted] a pink hat. Residents entered room 306. Between 2145 and 2146 various unknown residents entered and exited Room 306.
2146 Resident [redacted] entered room 306 and exited 306 carrying a wooden board. Resident [redacted] was in the hallway holding the wooden board, threatening staff. Staff were huddled in a corner.
2146 Resident [redacted] Resident [redacted] and Resident [redacted]0 entered room 306 (total of ten residents in room 306 - Resident [redacted], Resident [redacted], Resident [redacted]Resident [redacted] Resident [redacted], Resident [redacted], Resident [redacted].
2147 MM #8 was standing in the hallway looking into room 306, the door was open.
2147 The door was slammed shut to room 306.
2158 The door to room 306 opened and shut.
RN #2, MHT #13 and MHT #17 were standing at the opposite end of the hall.
2202 Resident [redacted](resident housed in room [redacted]) opened the door to room [redacted] and reported residents eloped through the window.
2203 RN #1 entered the 300 hall from the 200 hall. Resident [redacted] entered the 300 hall through the door behind RN #1 from the 200 hall and walked directly into Room 306. Resident [redacted] was the final resident to elope from Room 306.
100 Hall
1958 RN #1 enters the 100 hall from the 200 hall and walk toward the dayroom.
2000 Resident [redacted] and Resident [redacted] fighting in hallway over a piece of wall trim. MHT #11 picks up the trim and the walked toward the day room.
2001 Resident [redacted] in hallway with another piece of wall trim and enters room 101. RN #1 and MHT #11 come down the hall with Resident [redacted] Resident [redacted] hand the piece of wall trim to RN #1.

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MHT #11 standing at the door to room 101.
Resident[redacted] comes out of the room.
2002 MHT #11 removed the wall trim from Resident[redacted] RN #1 looking at the resident's arms.
2005 Resident[redacted] goes from the 100 to 200 hall when Resident[redacted] comes through the door from 200 hall.
2012 Resident[redacted] and another[redacted] resident trying to open 100/200 hall door. Two MHTs in hallway watching.
2017 Resident[redacted] pushed a chair from the day room up the hallway and rams it into the 100/200 door. MHT #11 and MHT #12 are at the doorway. RN #2 enters from 200 to 100 hall and pushed the chair back. Resident[redacted] returns to the 100 from the 200 hall. Resider[redacted] Residen[redacted] and [redacted] resident entered the 200 hall.
2019 through 2036 Resident[redacted]) and Resident[redacted] ([redacted]) were exiting and entering the 100 to 200 hall and 200 to 100 hall.
2036 Resident[redacted] comes through door from 200 to 100 hall, then returns to the 200 hall. MHT #11 standing at the 100/200 door holding it open.
2037 Residen[redacted] and MHT #10 enter the 100 from 200 hall.
2038 Resident[redacted] running down hall with a board in hand. MHT #10 attempting to remove the board.
2039 Resident[redacted] and MHT #10 enter room 101 together. Resident #[redacted] still has the board.
Resident[redacted] seen [redacted] in room[redacted].
Residen[redacted] and MHT #10 exit the room to hall. MHT #10 has the board.
2042 Resident[redacted] breaking a chair in the 100 hall day room. MHT #11 and Resident[redacted] present in dayroom.
2043 Resident[redacted] exits room 101 and goes toward day room.

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2045 Resident [redacted] tearing the chair apart and getting wooden boards from chair. MHT #10 taking the board from Resident [redacted] and gave to MHT #11 to lock in the bin room.
2046 Resident [redacted] and MHT #10 go into room 101.
2047 MHT #10 comes to room door and tosses a board toward the day room. Resident [redacted] exits room 101 with a board. Resident [redacted] using board to break thermostat. MHT #10 following.
2048 broken board thrown by Resident [redacted] 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 [redacted] goes into room 101.
2102 RN #1 returns to the 200 hall.
2106 Resident [redacted] 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 [redacted] comes from 200 to 100 hall, gets shoes.
2117 MM#8 exit the 100 hall to 200 hall.
2118 Resident [redacted] enter room 101. MHT #10 at the door.
2119 MHT #10 turns room light on. Resident [redacted] in bed in room 101. Resident [redacted] 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 [redacted] exits room 101 toward

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dayroom. RN #2 exits to 200 hall.
2123 MHT #12 exits 100 to 200 hall.
2124 MHT #12 returns to 100 hall.
2130 MHT #12 opened the 100/200 door. Resident[redacted] walked at a fast pace and lunged through the door to 200 hall. MHT #10 follows, but remains on 100 hall.
2131 MHT #12 returns to 100 hall.
2133 MHT #10 to 200 hall. Resident[redacted] (100 hall male) went to 200 hall.
2134 MHT #12 returns Resident[redacted] to 200 hall.
2135 MHT #13 enters 100 hall.
2159 hall video ends
200 Hall
1935 Resident[redacted] ([redacted]) goes through the 200/300 hall door from the 200 hall to the 300 hall ([redacted]) when staff come through the door
1936 MHT opens the door and allows Resident [redacted]) to go to from the 200 hall to the 300 hall ([redacted])
1941 Resident #8 ([redacted]) is on the 200 hall
1946 200/300 hall door open
1948 RN #1 standing at 200/300 hall door with it open
2003 200/300 hall door open. Resident[redacted] ([redacted]) is on the 200 hall
2005 Staff open door and let Resident[redacted] ([redacted]) come on the 200 hall
2012 Resident[redacted] ([redacted]) is in a hold in the hallway
2013 100/200 hall door is open
2014 Resident[redacted] ([redacted]) is in the hallway
2017 Resident[redacted] ([redacted]) goes through the 100/200 door to the 200 hall. Other[redacted] residents from the 100 hall went onto the 200 hall (Resident[redacted] and Resident[redacted]
2019 100/200 door remains open. Resident[redacted]

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Residen[redacted] ([redacted]) and Resident[redacted] ([redacted]) go to Resident[redacted] room 2020 Resident[redacted] moved off hall. 200/100 hall door remains open. RN #2 and Residen[redacted] 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[redacted]) opened door
2023 Resident[redacted] takes paper off the wall. Hallway is cluttered with paper on the floor toward the 200/300 end of the hallway.
2025 Resident[redacted] and Resident[redacted] ([redacted]) come on the 200 hall and return to the 100 hall. 100/200 hall door remains open.
2129 Resident[redacted] lunged through the door to the 200 hall.
2032 Resident[redacted] ([redacted]) returns to 100 hall. Resident[redacted] ([redacted]), Resident[redacted] ([redacted]) and Resident[redacted] ([redacted]) remain on 200 hall. Resident[redacted] back to 200 hall.
2037 Resident[redacted] ([redacted]) to 200 hall
2203 RN #1 entered the 300 hall from the 200 hall. Residen[redacted] entered the 300 hall through the door behind RN #1 from the 200 hall and walked directly into Room 306. Resider[redacted] was 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

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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[redacted] female residents and[redacted] 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[redacted]) off the unit to 300 dayroom. Resident[redacted] became upset and went after the other resident ([redacted]). Name (resident[redacted]) placed in hold by me. Name (MHT #34) back on the unit took Name (Resident[redacted]) to dayroom. Name (resident[redacted]) to her room. Name (MHT #17) and Name (MHT #13) came to unit. I went to rec room with 200 hall - Name (Resident[redacted]), Name (Resident[redacted]), and Name (Resident[redacted]. No one left on 200 hall. I believe Name (MHT #16) was on 200 hall. Name (Resident[redacted] would go to 300 hall for bath, had words with Name (resident [redacted]. Name (Resident[redacted] everybody out to get him and Name (Resident[redacted]) possible altercation with Name (resident[redacted]) were on the 300 hall ([redacted]) sitting on the floor. Name (MHT #15) and Name (MHT #14) were in the rec room. Name (resident[redacted]) started telling everyone wanted to see Name (resident[redacted] and Name (resident[redacted]8) fight. Name (resident[redacted]) 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

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no he was in coverage. Transitioned back to 200, when we get to 300 hallway door Name (resident [redacted] darts out of the 300 dayroom and runs onto the 300 hall and goes straight toward Name (resident[redacted]) room 305. Name (resident[redacted]) pushes through and joins in hallway outside of 305. Residents blocking so staff couldn't assist. Name (MHT #17) got Name (resident[redacted] away and placed in hold and transported to 200 hall. I grabbed Name (resident[redacted]) and place in safety hold. Name (resident[redacted]) threw a shoe and hit Name (resident[redacted]) in face, turned, Name (resident[redacted] hit Name (resident[redacted] in face. No injuries. Hold facing wall to see residents better. Escorted Name (residen[redacted]) back to room, stood at door. Name (resident[redacted] and Name (residen[redacted] antagonizing Name (resident[redacted]). Name (resident[redacted]) and Name (residen[redacted] still on the 300 hall from transition. Name (MHT #17) and Name (MHT #13) took Name (Resident [redacted] and Name (Residen[redacted] to the 200 hall. MHT #13 and MHT #17 return to 300 hall. MHT #17 takes my place at Resident #18's door and I went back to 200 hall. MHT #10 attempting to de-escalate Resident[redacted]. Antagonizing with residents on 100 hall Resident[redacted], Resident[redacted]. Resident[redacted] was programming with 200 hall only after altercation on 100 hall. Residen[redacted] was removed from the 200 hall. MHT #14 and I were trying to get the other residents situated in their rooms, med passes going on, don't recall if everybody or anybody got their meds. Chaotic every time the door would open kids would slip through. Door compromised, wouldn't shut. No one monitoring the door. Resident[redacted], Resident [redacted], Resident[redacted], Resident[redacted] and Resident[redacted] going into Resident[redacted] room destroying the room. Resident[redacted] was in this room at the time. Ask Resident[redacted] to step out and close the door (10 minutes). Mattress ripped open, crayons and

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books ripped, trying to tear Resident #16's clothes up. MHT #10 trying to get [redacted] out of room. Resident [redacted] tried to rip electrical socket out of the wall, kicking the doors. MHT 15, MHT #14 and MHT #10 would get Resident [redacted] off hall, then [redacted] would come back. MM #8 would stop, redirect, the [redacted] 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 [redacted] threw water in the outlet. Metal plate in ceiling bent on 100 per Resident [redacted]. 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 [redacted] went over (from 200 to 300) after kids got out window. RN #2 went back to 300. I looked through the door. Resident [redacted] pushed 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 y'all tell me the residents got out'." Interview revealed she (MHT #15) lost her walkie talkie during the physical hold with Resident [redacted] and didn't get it back prior to the end of the shift. Interview revealed "Name (RN #1) called Gear 3 but never came out. Nurse

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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 [redacted] and Resident [redacted]. 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." Interview revealed she attended a meeting with

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AS #21 on 01/10/2018 to discuss concerns with "safety, kids, staff responsibilities (who and when a gear should be called), ratio of staff to residents 2:6, competence issues, 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 extent, but some staff were afraid to intervene with residents. Interview revealed they discussed the number of staff terminated because of inappropriate holds.

Interview on 01/11/2018 at 1645 with MHT #14 revealed she was working the 7pm-7am shift on 01/01/2018 and was assigned to the 200 hall. Interview revealed she also worked the 7pm-7a m shift on 01/05/2018 and was assigned to the 200 hall. Interview revealed she had been working on the PRTF unit since May, 2016. Interview revealed she arrived in the recreation room with approximately nine to eleven 200 hall residents at 1930 on 01/01/2018. Interview revealed she and MHT #15 were the only staff in the recreation room. Interview revealed they left the recreation room between 2000 and 2030 to transition the 200 hall residents back to the unit. Interview revealed she did have a walkie talkie. Interview revealed a "Gear" was called prior to bringing the 200 hall residents back to the unit. Interview revealed "Resident #8 and Resident [redacted] made statement saying 'gonna get that ----'. We knew they were going to get someone but didn't know who." Interview revealed "When we transitioned through the 300 hall, Resident [redacted] raced into room 305 attacked Resident [redacted]. Came out of the room into the hallway fighting and MHT #17 and MHT #15 pulled them apart. Resident [redacted] started attacking Resident [redacted] and Resident [redacted] hit Resident [redacted] in the face with a shoe, then

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Resident[redacted] hit Resident[redacted] in the face with her hand. Resident[redacted] was placed in a hold and escorted to the 200 hall with other 200 hall residents. MHT #17 had Resident[redacted] in hold for approximately 15-20 minutes. To 200 hall after she couldn't get RN #1 to the 300 hall. Approximately 15 minutes after getting on 200 hall, believe I told her we had a hold, everything chaotic. I stood by 201 door where I was monitoring Resident[redacted] to make sure[redacted] didn't go through the bathroom between 305 and 201. After calmed down Resident[redacted] on 200 hall supposed to be on 100 hall. R.C. decision to let program. Resident[redacted] and Resident[redacted] ran into room 205 (Resident[redacted] room). Resident[redacted] in room 205 ([redacted] Managed to close and lock door. All acting out, Resident[redacted] and [redacted] trying to get to 300 hall every time staff opened door. Resident[redacted] standing at nurse's station asking to put papers on top of chart rack. RN #1 had papers on keyboard where meds are. Resident[redacted] grabbed papers, ran to 300/200 door and pushed through crack between doors. Resident[redacted] removed from unit. Told RN #1 about papers, she didn't bother to get papers. About 20 minutes later she went to get the papers. Resident[redacted] and Resident[redacted] trying to kick door open, didn't say much to him. Pulled metal cover out of ceiling, metal cover with key lock. Nurse Name (RN #1) say 'I'm not going through the door, y'all will have to come down the hall. Residents went midway down the hall stopped and took a stance. After RN #1 made way to 300, I said watch them behind you, Resident[redacted] said 'shut your ------ mouth. Another staff member came from the other direction, Resident[redacted] and Resident[redacted] had taken stance in middle of hallway and pounced when door open and accessed 300 hall. Never returned to 200 hall. So much going on in the 100 and 300 hall, I told Ms.

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Name (RN #1) she needed to call the police or nurse Name (RN #5). She was like where is the R.C., call the R.C. R. C. had someone in a hold. I said okay, call Ms. Name (RN #5). She (RN #1) texted RN #5. 15-20 minutes later RN #4 from Acute came over to nurse's station. RN #4 said 'This don't make no sense I am calling the police before someone gets hurts'. One of the staff from 300 told MHT #15 that window in room 306 had been broken and residents had eloped. Staff opened door and Resident [redacted] went through and eloped out of broken window.
Interview revealed MHT #11 came to the 100/200 hall door and said 'nobody here but myself, I need more staff.' I told him okay I will call someone to help him. MHT #11 said he did not have a radio so I gave him my walkie talkie." Interview revealed "I don't recall nurses coming out to help me. I would ask if I needed help."

MHT #14 stated "Name (RN #1) came out to get her papers that Resident [redacted] had taken out of the nurse's station. MM #8 found the papers and brought them to RN #1. She (RN #1) went back to nurse's station where she remained even after RN #4 came. RN #2 was out of the nurse's station helping to de-escalate. RN #1 said 'why didn't they call and let anyone know they had eloped', said she 'didn't hear them call no code purple or gear'. I heard one of the staff lost their radio to the residents. RN #1 hesitant due to being kicked in the head."

Interview revealed on 01/01/2018 "I was afraid for my life." Interview revealed she had received no education or follow-up since the 01/01/2018 and the 01/05/2018 incidents. Interview revealed "Gears" are called so the "nurse can come and observe." Interview revealed the nurse gives the okay to let a resident out of the manual hold.

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Interview revealed the doors between the hallways are propped open to the magnet after residents are in bed asleep. Interview revealed "perhaps only 1-2 staff on the whole 100 hall. PRN MHT called into work on a different night after the 01/01/2018 incident. I was on the hall alone with 11 residents when he left at 0000.

Interview on 01/17/2018 from 1435-1450 with MHT #12 (Mental Health Technician) revealed he was working the 7pm-7am shift on 01/10/2018. Interview revealed he was in report at 1930 for debriefing from day shift. Interview revealed Resident [redacted] became angry prior to my shift. Interview revealed Resident [redacted] was very active. He ripped out the bathroom mirror and the commode seat in Room 104. He broke a chair to use as a weapon. Interview revealed "I went into the bathroom to talk [redacted] out, Name (MHT #10) was there. Name (resident [redacted]) came out of bathroom and said 'Someone mess with me I'm going to — you up' and swung one time." Interview revealed another resident walked into room 104 and wanted to use the broken objects to hurt [redacted]. Interview revealed Resident [redacted] said "It's gonna happen tonight." Interview revealed he told Resident [redacted] at he was not here to hurt [redacted] and ask how they could help [redacted] Interview revealed Resident [redacted] said "We passed that point. I'm gonna — you up." Interview revealed he (MHT #12) tapped MHT #10 and said "I need to step away. I walked to nurse Name (RN #1) in the nurse's station and asked to step off the unit. I went to the 300 dayroom. I felt like I was being a target. It was chaotic. Ms. Name (RN #1) was aware of the situation." Interview revealed "I was back on the hall prior to the elopement. Asked for keys and to move patients off the hallway." Interview revealed MHT #17 and

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MM #8 moved females off the 300 hall. Interview revealed "Nobody wanted to get hurt." Interview revealed he met with AS #23 face-to-face and spoke with her by phone after the elopement.

Interview on 01/17/2018 from 1215-1320 with MHT #10 revealed he worked the 7p-7a shift on 01/01/2018. Interview revealed a "Code Purple male staff needed" was called between 1900 and 1930 during shift change on 01/01/2018. Interview revealed MHT #10 and MM #8 walked upstairs, "destruction" appeared to be "manageable with first shift there." Interview revealed the 200 hall (mixed girls/boys) were taken to the recreation room during the 100 hall medication dispensing that occurs during change of shift around 1900-2000 to better manage the medication administration for the 100 hall ([redacted]. Interview revealed he remained on the 200 hall peeping through the door at the 100 hall. Interview revealed he gave the "all clear" for the 200 hall to transition back to the PRTF unit. Interview revealed he "vaguely remembered nurse Name (RN #1) giving medications" and "Name (RN #1) could have said to me or by radio that she was ready for 200 hall, not exactly sure. Normally she (nurse) says she is ready for 200 hall and we call the all clear." Interview revealed "We have been short staffed." Interview revealed shift change report is held in the downstairs break room from 1900-1930 and all 2nd shift staff should be on their assigned unit at 1930. Interview revealed the day shift staff should not leave the unit until relieved by night shift staff. Interview revealed the staff should be together during the transition of residents. Interview revealed there was a verbal/physical altercation on the 300 hall ([redacted]) when the 200 hall was transitioned back to 200 from the Recreation Room. Interview revealed MM#8 was on the 300

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hall managing/redirecting. Interview revealed when he arrived on the PRTF unit he immediately checked on the 100 hall [redacted]). Interview revealed Resident [redacted] was on the 200 hall being "disruptive and impossible to redirect back to 100 hall. I don't think [redacted] was 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 [redacted] 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 [redacted] managed to get down the hall with the chair with no redirection." Interview revealed Resident [redacted] "jumped through the 100/200 hall door and got onto the 200 hall. All my energy was directed to Name (resident [redacted]). [redacted] went to Name's (resident [redacted]) room, tearing up the resident's clothing. Turned back to Name (resident [redacted]), struck in head by Name (resident [redacted], prompted to leave room, staff removed Name (resident [redacted])." Interview revealed Resident [redacted] and other residents tried to "tear (resident [redacted]) 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 [redacted] (resident [redacted]) was a kid. Because of [redacted] strength, the only thing I could do was grab [redacted] arm. I was not physically thinking about putting Name (resident [redacted]) in a hold. Not successful calming [redacted] down, stopped [redacted] from hurting another person. [redacted] 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

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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[redacted]). He got on the 200 hall, remember Name (resident[redacted]) talking to saying ———." Interview revealed he was eventually able to get resident[redacted] back on the 100 hall and calmed down, even though [redacted] was still destroying furniture. Interview revealed there were 2 male staff working on the 100 hall.

Interview revealed resident[redacted]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[redacted]. Interview revealed MM#8 took over re-directing of resident[redacted] and removed him from the 300 hall. Interview revealed MM#8 left the 300 hall after "I was pushed by Name (resident[redacted]) and struck in the left ear by Name (resident[redacted]." 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 and was picked up by another resident and slammed down on his feet but was not hurt.

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Interview revealed "Name (resident [redacted]) spit in my face. I went to the manager's office to calm myself down, then I went to the Milieu 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 [redacted] was pacing on the 300 hall when the altercation between the [redacted] residents started. Interview revealed the [redacted] altercation on the 300 hall began in room 305 and ended up in the hallway. Interview revealed MHT #10 was with Resident [redacted] on the 200 hall at the nurse's station. Interview revealed the medication passes were

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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 [redacted]) had been placed in a hold earlier this would have never got this bad. Residents should have been 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 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 [redacted] came out of room 306 holding a board with nails. Resident [redacted] was rolling up towels. Resident [redacted] pushed and spit on MHT #10. Resident [redacted] picked MHT #10 up and he put him down, did not hit the floor."

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

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eloping. Interview revealed MHT #10 left the 300 hall after he was spit on and never returned to the unit. MHT #10 went home.

Interview revealed there had been no change in staffing on the units since the incidents and re-training on gears/de-escalation. Interview revealed the administrative staff met with them for 2 hours at the beginning of their 7pm-7am shift on 01/10/2018 to review concerns. Interview revealed the meeting information needed to be more in depth. Interview revealed the PRTF unit was not any safer because nothing had changed. Interview revealed some identified safety issues include the "new medication pass process, doors between residents' hall being held or propped open and activity coming in."

MHT #12 was contacted on 01/17/2018 at 1017 and indicated he was not available for interview.

Interview on 01/16/2018 at 1640 with MM #8 revealed he was working during the incident on 01/01/2018. The staff member stated "It lasted a long time. The 100 hall residents were on the 200 hall. All three halls were in disarray. All the residents were in the hallways, ignoring all directions." Interview revealed there were two scheduling teams that worked called the pink team and the blue team. Interview revealed the blue team was working on 01/01/2018. MM #8 reported that the pink team is stronger because the blue team has lost several staff over the past two months. He stated there had been at least five terminations in the past two months, so the blue team was not fully staffed. MM #8 stated "there was adequate staff by numbers, but the quality or ability of the staff was inadequate." Interview revealed there was a Code Purple called on the 100 hall at shift change, around

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1930. MM #8 stated "Staff opening the door was stupid. They got from 200 to 300. 100 residents got to 200 hall and they were excessively non-compliant and at the same time there was an incident going on the 300 hall. (Resident[redacted]) was banging something against the door. Later I saw it was broken boards." MM #8 stated he had gone outside when the residents eloped and one of the residents said "Lets rush." Interview revealed they were threatening to rush MM #8 and he got into his car and tried to keep visual line of sight on the residents, but lost them. MM #8 reported he didn't call the police. He stated he went to the nursing station and asked RN #1 for AOC (Administrator on Call) and was told by RN #1 that she didn't have that information, and that she was on the phone with RN #5. MM #8 stated that RN #4 called 911, the receptionist called 911 and Kendall called 911 around 2150. MM #8 stated they were "constantly calling Code Purples that night and never got a response. (RN #1) stated she never heard a Code Purple." Interview revealed RN #1 had sent RN #5 pictures of the property damage. Interview revealed the nurses were "in charge in the milieu as a general rule. For a large part of the night, she (RN #1) was in the nursing station."

Interview on 01/16/2018 at 1725 with RN #2 (date of hire 10/09/2017) revealed she worked 7pm - 7am on PRTF on 01/01/2018 and was present during the elopement incident. Interview revealed the nurse works as needed, usually one to two times a week. Interview revealed the nurse was not aware that she could call the police when the incident happened on 01/01/2018. The nurse stated when she arrived for work, the milieu was not calm, the residents were hyper and things got progressively worse. RN #2 stated "We lost control. It was totally out of control. They

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(residents) were not following directions. I was in the hallway when (Resident [redacted]) broke the furniture [redacted] went through each unit, 100, 200, 300. We (nurses) should have had a three minute conference to determine what to do. [redacted] (Resident [redacted] needed to be restrained or secluded [redacted] was out of control. I was not the nurse in charge. I told (RN #1) over and over [redacted] was out of control. I don't know if she notified the doctor. The girls were fighting. Resident [redacted] was the catalyst. [redacted] had power more than anyone else. We lost control of the unit. The kids had plenty of control. The boys came through to 200 hall with Resident [redacted] I never saw Resident [redacted] with a board. I was told about it and told [redacted] was flailing it around. I did not see (RN #1) on the unit that night. I had a walkie (talkie). I am not sure if she (RN #1) had a walkie (talkie)." Interview revealed there is a walkie talkie in the nursing station and it is always on. Interview revealed RN #4 from the acute area came over to assist and RN #2 found out that she could call the police. The nurse stated there were no Code Purple incidents called on 01/01/2018. Interview revealed code purples are announced overhead and on the walkie talkies. Interview revealed the code purples could be heard in the nursing station and both nurses would respond.

Interview on 01/11/2018 from 0955-1035 with RN #1 (date of hire 09/29/2016) revealed she started working as a travel nurse 2 years ago and took a full time nursing position 1 year and 4 months ago. Interview revealed she was the nurse in charge of the PRTF unit on 01/01/2018. Interview revealed she arrived on the unit at 1900. Interview revealed many of the kids were agitated, but she did not recall on which hall. Interview revealed "The residents are out of sort at shift change." Interview revealed she spoke

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with RN #5 (DON) about the residents' behavior at change of shift. Interview revealed medications are scheduled for 2000 and we usually start the medication pass around 1900. Interview revealed at 2030 "The kids were acting up so I texted Name (RN#5) for more help. I told her we needed more help. I didn't feel the amount of staff we had was enough to de-escalate what was going on. She (RN #1) asked about the R.C. (resident coordinator). Name (MM #8) informed about MHT and he said he would call Name (RN #5) about more staff." Interview revealed "I was in and out a lot to attempt de-escalation. I called Name (RN #5) as my supervisor and asked her to call the AOC (administrator on-call), as I didn't know who was on call. I can't tell specific incident, but felt something was building up. I was out on the floor and in the nurse's station."

Interview revealed the R.C. on the hall is typically asked which hall they want to start the medication pass on first. The 200 hall (mixed boys/girls) are typically moved to the recreation room. Interview revealed she did not remember if they were moved on 01/01/2018 and she did not recall if any residents were on the 200 hall during the medication pass. Interview revealed around 2200 another nurse received a call from Name (RN #3) telling her the kids were breaking out the window. Interview revealed "I had no call to tell me. I asked why they didn't radio." Interview revealed there were lots of things going on in the unit. Interview revealed the police came, got descriptions and began looking for the residents. Interview revealed "I was completing incident reports and other paperwork." Interview revealed the residents were returned approximately 2 hours later by the police department. The residents were assessed by Name (RN #5) and Name (LPN #7) or Name (LPN #6). Interview

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revealed the residents were placed in paper scrubs after return from elopement. Interview revealed there are monitors in the nursing station that allows the nurse 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 someone to watch monitors." Interview revealed she charted once a shift around 2330.

Interview revealed de-escalation techniques were ineffective on 01/01/2018. Interview revealed "Each room has a table. Name (Resident [redacted]) broke a table on the 100 hall, tore outlet out, tore part of the ceiling down in the hallway and pulled the trim off around the window." Interview revealed the provider was notified after the elopement. Interview revealed "I did not call the provider for medications." Interview revealed "The doctor left that used to give standing orders. The new doctors wants call for each resident. Name (Resident [redacted]) needed to be in a hold. Nurse makes decision. Not enough staff. Two staff on 100 hall, don't recall census or staffing on 200/300 halls." Interview revealed the staff had a difficult time keeping the residents on their appropriate hall.

Interview revealed the medication process involves "The staff bring one patient at a time. 100 MHT opens door. Radio to MHT on 100, ready for meds, sends patients one at a time. Try to do that, boys overpower the MHT and get through the door. Has happened before. Staff on 200 hall will assist with trying to get them back. Patients crossed on 01/01/2018. I went out here and shut nurse's station door and talked with the kids, not successful, I don't recall what I did afterwards. I don't remember if I called maintenance. We call directly. I did not see

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maintenance prior to end of shift." Interview revealed "Lot involved don't recall. Don't recall hall where Name (Residen[redacted]) 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 de-escalate. 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. 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

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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, 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

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dayroom) was removed and carried outside the building. Interview revealed he took the "planks" that had been removed from the chair and put "security screws in the slats." Interview revealed the double door between the 100 and 200 halls were not latching properly from where it had been kicked. He shaved top to get latch to work properly. He tightened the screws down in the doors between the 200 hall and 300 hall to "allow for easier opening." Interview revealed he removed the "plexi-glass in room 106 (Resident [redacted] room)" and "replaced with a new piece" on 01/01/2018. Interview revealed he was not notified of the 100/200 hall door not closing automatically prior to the elopement/window damage.

Telephone interview on 01/09/2018 at 1015 with RN #3 revealed he was notified by MHT #10 on the evening of 01/01/2018 that the PRTF was "falling apart and no one had called administration." The nurse stated MHT #10 had come to the eye wash station because a resident had spit in his eye. RN #3 reported that he and another nurse had gone to the PRTF 300 hall and "found three techs huddled at the end of the hall close to the doc station." The nurse stated he heard a loud noise and cussing, saw trash and garbage all over the floor in the hallway. He stated residents had barricaded themselves in a resident room and had weapons made from the desks in the room, described as "boards with six inch screws in the board." The nurse stated there was no staff trying to get into the room and he was told by the staff "They have weapons. Don't go in." The nurse described the situation as a "riot, complete breakdown." RN #3 stated MM #8 told him that the residents were kicking out a window and the nurse stated he went to the front outside of the building and saw the resident

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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 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'.

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Interview revealed she thought to herself, it can't be that bad. Interview revealed she walked over to the 300 hall and found the unit was indeed out of control and residents were barricaded in room 306, beating on the window, trying to break it and get out of the facility. Interview revealed she told MHT #16 to call 911 while she went to the PRTF nurse's station to speak with the nurse and find out what was going on. Interview revealed she found RN #1 in the nurse's station texting the DON. Interview revealed RN #1 did not come out onto the halls while she was on the unit. RN #4 stated "the kids outnumbered the staff." Interview revealed the other nurse on the acute unit (RN #3) had walked to the front door and saw MM #8 in the yard outside the 306 window trying to keep the residents in the building. Interview revealed RN #3 told her the "residents overpowered MM #8 and he was unable to keep them inside." RN #3 told RN #4 that the residents made a comment to or at him, so he stepped back inside the building and asked the receptionist to call the police due to residents had eloped.

Interview revealed there were 2 "Code Purple" called prior to the elopement around 2000 and again before 2100. Interview revealed the "Blue Team" doesn't function as well as the "Pink Team". Interview revealed she worked with both teams. Interview revealed she will work on the hall as a MHT if they are short staffed. Interview revealed the R.C.'s are assigned a hall on the assignment sheet, but they typically roam and assist as needed. Interview 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;

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300 hall 9 residents with 3 MHT's; 1 RN and 1 LPN on the PRTF unit.

Interview revealed assignment of admissions are made on the 200 hall by the nurse on day shift and the DON. Interview revealed residents with the same characteristics are admitted to the 200 hall. Interview revealed recently, "All admissions to 200 hall if bed available." Interview revealed assignments for night shift are made when she arrives for her shift. Interview revealed all room changes had to been approved by the previous CEO, however now she can make room changes but has to deal with leadership the next day as to "who authorized the room change." Interview revealed the nurses and mental health techs work together to make decisions, however the "residents will manipulate room changes."

Interview on 01/17/2018 at 0945 with RN #4 revealed she had no incidents over the weekend except for the usual physical holds and staffing was okay. Interview revealed the "night shift report from other nurses. Get the intake assessors. May not have all information. Resident[redacted] and Resident[redacted] should not have been placed in the same facility. Hx: knew each other and in same group home. Didn't know elopement risk until 1 week after residents arrived. Sometimes the assessors' sheets are not there. No access to share drive." Interview revealed the administration on call schedule is printed in the front office and brought to the unit to be posted on the bulletin board. Interview revealed she sends a group text to the administrator on call (AOC), DON and physician to notify them on any problems, issues or concerns.

Interview on 01/17/2018 at 1110 with AS #24

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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 [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) on [redacted] 2017 with diagnoses of [redacted]. Review of the intake assessment revealed the resident [redacted]. Further review of the intake assessment revealed documentation of homicidal risk and elopement risk related to the resident [redacted]. Record review revealed Resident #1 had a known history of elopement on admission and eloped from the

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facility on 01/01/2018.
Admission vital signs were [redacted] Review of the Psychiatrist Evaluation documented on [redacted]/2017 at 2050 revealed "..[redacted]..." Review of the medical record revealed documentation of a [redacted] for Resident #1 on 01/02/2017 from 1321-1342 for [redacted] Review of the Medication Administration Record revealed documentation of [redacted] administered on 01/05/2018 no time. Review of the Restrictive Intervention documentation dated 01/05/2018 at 2015 revealed a physician order for [redacted] for [redacted] Resident #1 was [redacted] and [redacted]. Resident #1 was [redacted]. Restrictive intervention documentation revealed Resident #1 was [redacted] on 01/05/2018 at 2015 and [redacted] at 2040. Restrictive Intervention documentation revealed Resident #1 was [redacted] at 2025. Review of the medical record revealed a nursing note documented by RN #5 on 01/05/2018 at 2040 that recorded "[redacted]

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[redacted]." Review of the medical record revealed documentation of a [redacted] for Resident #1 on 01/05/2018 from 2015-2040[redacted] Review of a nursing note documented by RN #5 at 2130 revealed [redacted]." Review of nursing note documented by RN #5 revealed [redacted]." Review of restrictive intervention documentation revealed Resident #1 was [redacted] on 01/05/2018 at 2224 after [redacted]. Resident #1 was [redacted]. Documentation revealed Resident #1 was [redacted] on 01/05/2018 at 2323. Review of an Observation Sheet dated 01/05/2018 revealed the resident was assigned to Room [redacted] on

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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 "[redacted] Review of the night shift notes dated 01/05/2018 recorded by MHT #11 revealed "[redacted]." Review of physician orders revealed a telephone order dated 01/05/2018 at 2224 for [redacted]" for [redacted]. Review of orders revealed a telephone order dated 01/05/2018 not timed "[redacted]" Review of the medical record revealed documentation of [redacted] for Resident #1 on 01/05/2018 from 2224-2323 for [redacted].

Review of orders revealed a telephone order dated 01/06/2018 at 2224 "[redacted]." 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 "[redacted]

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[redacted]."

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 dated 01/08/2018 at 1335 [redacted]."

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 [redacted]."

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 [redacted]." 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

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recorded "[redacted]." 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 [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) on [redacted]/2017 as [redacted] Review of the record revealed admission diagnosis included [redacted] 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 [redacted]/2017 recorded by a [redacted]r revealed [redacted]. Review revealed the resident has [redacted] Review revealed on [redacted]/2017 the resident [redacted] The resident was [redacted]. Review of a Comprehensive Psychosocial Assessment Tool documented by [redacted] on 12/19/2017 (not timed) recorded the resident [redacted]." Review of

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admission orders dated [redacted] 2017 revealed the resident was placed on [redacted] with every 15 minute observation checks. Review of a nursing note documented by RN #5 on 01/05/2018 at 2030 revealed the resident [redacted] Notes recorded [redacted]. Review revealed an order was received for [redacted] and the medication was not administered because [redacted]. Review of the emergency restrictive intervention revealed the resident remained [redacted] from 2015 through 2040. Nursing notes recorded by RN #5 on 01/05/2018 at 2130 recorded [redacted]. Notes recorded [redacted]. Notes revealed the legal guardian was notified. Review of physician's orders revealed a telephone order dated 01/05/2018 (not timed) to [redacted]. Review of an Observation Sheet dated 01/05/2018 the resident was in [redacted] at 1530 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 [redacted])..."

3. Open medical record review of Resident #8 revealed a [redacted] admitted to the

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PRTF on [redacted]/2017 with [redacted]. Review of a Comprehensive Psychosocial Assessment Tool completed by [redacted] on [redacted] 2017 at 1000 revealed the patient stated, [redacted]." Record review revealed Resident #8 had a known history of elopement on admission and eloped from the facility on 01/01/2018. Review of admission orders revealed the resident was placed on every 15 minutes observation. Review of nursing notes documented by RN #5 dated 01/05/2018 at 2200 revealed [redacted]."

Review of a Health Incident Review Report for Resident #8 dated 01/05/2018 at 2030 revealed "[redacted]---"

4. Closed medical record review of Resident #3 on 01/09/2018 revealed a [redacted] admitted to the PRTF on [redacted]/2017 as a [redacted]. Review of the record revealed the admission diagnosis was [redacted]. 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 Note" written on 01/03/2018 at 1132 revealed

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"([redacted]..." Review of a nursing note dated 01/05/2018 at 2330 revealed "..[redacted]..." Review of a nursing note by RN #5 on 01/05/2018 at 2200 revealed "[redacted]..." Review of physician orders dated 01/05/2018 at 0320 revealed "[redacted].." Review of a nursing note dated 01/06/2018 at 0130 revealed "[redacted]..." Review revealed Resident #3 was [redacted].

Review of a Health Incident Review Report dated 01/05/2018 at 2030 revealed "[redacted]..."

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5. Review on 01/11/2018 of the medical record of Resident #9 revealed a [redacted] admitted on [redacted]/2017 to the facility due to [redacted]. Review of the Intake Assessment dated [redacted]/2017 revealed Resident #9 was at risk for elopement with a history of "[redacted]." Record review revealed 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 [redacted]. Review revealed Resident #9 lived on the [redacted] hall. Review of a physician order dated 01/02/2018 revealed Resident #9 was placed on [redacted]. Review of a nursing shift note dated 01/05/2018 at 2200 revealed Resident #9 was [redacted]. Resident #9 was [redacted]. Resident #9 was [redacted]

Review on 01/11/2018 of the Health Incident Review Report dated 01/05/2018 revealed Resident #9 [redacted]. Additional review revealed Resident #9 [redacted].

6. Open medical record review on 01/10/2018 for Resident #10 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) from [redacted]

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[redacted]/2017 with a diagnosis of [redacted]. 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 revealed Resident #10 arrived on the PRTF unit at 2[redacted]. Review of nursing notes revealed the resident was [redacted], with no complaints of pain or discomfort. Review of the nursing notes revealed the resident had old injuries noted to [redacted]. Admission vital signs were [redacted]. Review of the intake assessment revealed the resident was currently [redacted]. Further review of the intake assessment revealed documentation of elopement risk related to [redacted]. Review of nursing notes dated 01/05/2018 at 2200 revealed Resident #10 "[redacted]." Review of telephone order dated 01/05/2018 not timed revealed an order to "[redacted]." Review of a 7pm-7am nursing shift note dated 01/06/2018 at 0130 revealed "[redacted]." Review of an Observation Sheet dated 01/05/2018 revealed the resident was assigned to Room [redacted] 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 "[redacted]

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[redacted] Review of the night shift notes recorded by MHT #16 revealed the resident was "[redacted]." Review of an Observation Sheet dated 01/06/2018, 01/07/2018 and 01/08/2018 revealed the resident was assigned to Room 104A on 01/06/2018, 01/07/2018 and 01/08/2018. Review of the Observation Sheet dated 01/06/2018, 01/07/2018 and 01/08/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at "[redacted]

Review of a Health Incident Review Report completed by RN #1 and dated 01/05/2018 recorded "[redacted]." Review of the report revealed the date and time of the incident was 01/05/2018 at 2030.

7. Open medical record review of Resident #12 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted] Review of a Comprehensive Psychosocial Assessment Tool completed by [redacted] on 10/19/2017 at 1703 revealed the patient had a "[redacted]." Record review revealed Resident #12 had a known history of elopement on admission and eloped from the facility on 01/01/2018. Review of admission orders revealed the resident was placed on every 15 minutes observation. Review of an

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Observation Sheet dated 01/05/2018 revealed every 15 minute checks were documented from 0000 through 2345. Review revealed the resident was located at "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted]. Review of Night shift notes recorded by MHT #16 revealed "[redacted]..."

Review on 01/16/2018 at 1435 of the 100, 200, and 300 hall video monitor recordings for 01/05/2018 revealed:
Residents [redacted] wearing bandanas, double layers of clothing and / or jackets between 2010 through 2107 .
2010: Resident [redacted] 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 Resident [redacted] (200 hall [redacted]) from the 100 hall back to the 200 hall. The 100 to 200 hall door was opened and Resident [redacted] charged the door. MHT #18 and #26 prevented Resident #1 from entering the 200 hall.
2015: RN #27 opened the 200/100 hall door and Resident [redacted] (all [redacted] ts) charged the door and entered the 200 hall. MHT #12, #16, and #26 entered the 200 hall with the residents.
2016: Resident [redacted] were escorted back from the 200 hall back to the 100 hall.
2020: Resident [redacted] was in a manual hold by MHT #18 on [redacted] hall. Resident [redacted] was pacing the 200 hall and kicking the 200 hall doors. MM #8 was walking around with Resident [redacted]
2024: Resident [redacted] had broken DVDs

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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 [redacted] escorted from the 200 hall back to the 100 hall
2032: Resident [redacted] was placed in a manual hold by MM#8 on 200 hall. RN #1 was observing the manual hold. Resident [redacted] was escorted back to the 100 hall from the 200 hall by MHT #16 and #17.
2032: Resident [redacted] came into the hall way from the 100 hall dayroom with a wooden board.
2033: MHT #26 took the wooden board from Resident [redacted].
2033: MHT #16 entered the 200 hall and Resident [redacted] 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 [redacted] walked towards MM#8 who was manually holding Resident [redacted] on the 200 hall. MHT #18 placed Resident [redacted] in a manual hold. LPN #6 entered the 200 hall from the 100 hall and Resident [redacted] charged the door and entered 200 hall.
2035: Resident [redacted] escorted from 200 hall back to the 100 hall by LPN #6. Resident [redacted] kicked MHT#18 who was holding Resident [redacted]
2036: Resident [redacted] was released from a manual hold on the 200 hall.
2037: Resident [redacted] walked toward Resident [redacted] who was being manually held by MM#8 on the 200 hall.
2039: Resident [redacted] was in the 100 hall dayroom and pulled a wooden board from a chair and went into the 100 hallway. LPN #6 escorted Resident [redacted] from the 200 hall back to the 100 hall.
2040: MHT #11 took the wooden board from Resident [redacted] and placed it in the bin closet on the

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V 115	Continued From page 108 100 hall. MHT #16 escorted Resident [redacted] from the 200 hall back to the 100 hall. 2041: Resident [redacted] kicked the window in the 100 hall dayroom multiple times. 2042: Resident [redacted] entered the 100 hall dayroom with a wooden board and was hitting the window with the board. Resident [redacted] was given the wooden board by Resident [redacted] and also hit the window. Review revealed no staff were present at this time. 2043: Resident [redacted] had a chair from the 100 hall dayroom and was charging the 100/200 hall door with the chair. 2045: Resident [redacted] had a DVD and was attempting to cut [redacted] arm with the broken DVD in the 100 hall dayroom. MHT #17 took DVD away from Resident [redacted] 2047: Resident [redacted] escorted back to 100 hall from 200 hall. In the 100 hall dayroom Resident [redacted] got a piece of a wooden board from the chair and entered the 100 hall. 2049: A piece of wooden board w	V 115		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 CLIENT RIGHTS. PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and	V 512	V 512 Failure to secure unit doors between units and providing the supervision necessary to ensure the health and safety of PRTF residents and staff resulting in patient elopements and staff assault for 10 of 10 sampled patients that eloped (#1, #2, #11, #7, #12, #9, #10, #8, #3, and #6). Failure to communicate resident's patterns of elopement and history of violent behaviors, failure to implement policies and practices leading to destruction of equipment and patient elopement The following corrective actions are being taken to address the identified issues:	

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V 512	Continued From page 109 aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on policy review, medical record review, video review, police report review, Code Purple log review and staff interview, the facility neglected to ensure the safety of PRTF residents by failing to secure unit doors between units and providing the supervision necessary to ensure the health and safety of PRTF residents and staff resulting in patient elopements and staff assault for 10 of 10 sampled patients that eloped (#1, #2, #11, #7, #12, #9, #10, #8, #3, and #6). The findings included: Review on 01/09/2018 of policy title "Code Purple" last Reviewed/Revised 12/2016 revealed "Policy: To correctly identify steps to be utilized in the event of a Code Purple (psychiatric emergency) ...1. A group of RAs will be identified on each shift to be a part of the Code Purple Team ... 3. When a staff member notes that a resident is exhibiting signs of escalated behavior ... the Code Purple will be announced over the walkie-talkie with the location attached to the code ... 7. Code Purple team members will arrive at the announced location and take direction and	V 512	**Root cause (contributing factor):** **1)Criteria for admission did not exclude patients with history of aggressive behavior, elopement, or pending legal charges** (a) The criteria for admission to the PRTF for SBC Charlotte have been revised to now exclude patients with history of felonious behavior, history of elopement from a facility, history of gang involvement, history of substance abuse disorder, and history of a conflict or affiliate relationship with a current resident of SBC Charlotte. Attachment "A" shows the revised criteria for SBC, Charlotte, PRTF. SBC Charlotte is currently evaluating if these same criteria will be applied to patients within the acute care setting. **(b) Date of Completion:** Approved by the Governing Board 01/ 26 /2018 and now in place for PRTF units. **(c) Responsible Person**: Chief Executive Officer **Monitoring Procedure to Ensure Correction:** 1) (a) (1) All admissions will be reviewed by the Admissions Coordinator and the CEO for evidence of compliance with exclusionary criteria. (a) (2) On a weekly basis, SBC, Charlotte will conduct a PRTF Performance Improvement (PI)Committee meeting. A Governing Board Member will be a weekly participant to hear the results presented at this meeting. Attachment "B" delineates the standing agenda for this meeting.	1/26/18

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V 512	Continued From page 110 cues from the primary staff member on the scene ... 9. The primary staff member on the team will work collaboratively with the RN to de-escalate the resident. 10. Based on the level of danger to self/others, the primary staff and RN will cue the Code Purple team members into position if there is a need for physical restrictive intervention. ..." Review on 01/09/2018 of policy title "Position Summary - Registered Nurse" Date Approved: 01/31/2015 revealed "...The Registered Nurse...May assume a coordinating or supervisory role with assigned licensed nursing and milieu personnel i.e. assignments, monitoring schedule/work, follow-through and high acuity direction...Effectively respond and actively participate in a psychiatric crisis to resolution...Therapeutic Milieu 2. High visibility during increased acuity and takes an active role with indicated interventions..." Review on 01/10/2018 of the facility policy titled "Elopement" reviewed/revised on 12/2016 revealed "...will maintain a safe and secure therapeutic milieu for all clients receiving inpatient treatment. Procedure: 1. In the event of an elopement, the code, 'CODE GREEN' and location will be announced over the intercom. 2. Call (Name) police department immediately. Give names of the clients. Have a description of the escaped client - name, height, weight, sex, and age. When the police arrive give a copy of the photo ID of the client from the chart. 3. The RN will immediately notify the client's physician, the Medical Director, the Administrator on Call, and the client's legal guardian ...6. When the resident is located, the RN will notify the physician for a determination of whether the resident is to be evaluated at the Emergency Department prior to return to the facility. 7. The client will immediately	V 512	**(b) Date of Completion:** Approved by the Governing Board 01/ 26 /2018 and now in place for PRTF units. **(c) Responsible Person**: Chief Executive Officer **(d) Monitoring Procedure to Ensure Correction:** 1) (a) (1) All admissions will be reviewed by the Admissions Coordinator and the CEO for evidence of compliance with exclusionary criteria. (a) (2) On a weekly basis, SBC, Charlotte will conduct a PRTF Performance Improvement (PI)Committee meeting. A Governing Board Member will be a weekly participant to hear the results presented at this meeting. Attachment "B" delineates the standing agenda for this meeting. One of the indicators for review will be compliance with the exclusionary criteria for all prospective admissions. The results, conclusions, and recommendations 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. **Root cause (contributing factor):** **2)Patient details of prior history were not always present at the time of the initiation of the treatment plan and, thus, incorporated into same.** (a)2)(1)) A hand-off form and formalized procedure 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	2/18/18

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V 512	Continued From page 111 be placed on elopement precautions ... and the attending physician will be consulted for any further orders." Review on 01/10/2018 of the facility policy titled "Elopement Precautions" reviewed/revised 12/2016 revealed "... Residents who talk of running away, participate with or know of a planned runaway or actually run away will be placed on elopement precautions ...Procedure ...2. The adolescent who returns from an elopement must write a detailed narrative describing the events prior to the run, the run itself, and what transpired while the resident was away. This narrative must complete prior to the client being removed from elopement precautions. The narrative should include an effort to discover an alternative manner of coping, other than running away. 3. Adolescents on elopement precautions will have a bedtime of 8:30 pm every night. 4. Adolescents will be provided foam slippers to use as footwear. No shoes will be permitted. 5. Residents will not be allowed to leave the unit. 6. The individual's treatment plan will be modified to reflect the interventions necessary to maintain safety, i.e. room search daily, limited phone calls. 7. A physician's order will be required to remove the resident from elopement precautions. 8. Criteria for advancement from elopement precautions include: no dangerous behavior to self or others, no sneaky or suspicious behavior, compliance with rules/medications, the willingness to talk with staff regularly about concerns/feelings." Review on 01/11/2018 of the facility policy titled "Admission Procedures" reviewed/revised 12/2016 revealed " ...B. Belongings are to be itemized on the belonging list when brought to the unit ...C. Patient may keep at bedside a	V 512	precautions shall be written on the form entitled: "High Risk/High Alert Hand-off" and must be handed to the receiving nurse for their acknowledgement and signature of same. Report on precautions must be provided verbally (in person or per telephone) to the receiving Unit nurse prior to the patient being integrated into the nursing unit environment. The Unit nurse, in turn, will be responsible for implementing all orders and processes that accompany the specific precautions. Attachment "C" delineates the hand-off form and associated policy. During daily Administrator on Call rounds, the AOC will check the 15-minute check sheets for evidence of appropriate stickers signifying patient safety precautions that must correspond with those precautions identified by the High Risk/High Alert Hand-Off and, as ordered by the patient's physician. Deficiencies noted will be immediately corrected. Staff not meeting these requirements will be addressed on a progressive disciplinary basis. a)(2) A patient safety notification system has been developed whereby all patients on the PRTF are having identification stickers that are color- coded with level of precautions placed on their 15-minute round sheets. According to this system, based on their identified safety need, patients will have a red, yellow, or green level of precaution assigned. For example, patients on elopement precautions will be identified on their 15-minute check sheet as such and staff must ensure that they adhere to all provisions of the Elopement policy including restriction on outdoor activities, as ordered by the patient's physician. Attachment "D" delineates the new process for patient safety notification. During daily Administrator on Call rounds, the AOC will check the 15-minute check sheets for	2/18/18

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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 location ...5. 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 documentation will facilitate the recording of accurate, timely data, which reflects the current status of the client, the care provided, and he progress made by the client. Procedure ...2. 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 Nurse will document ...summary documentation will be completed every seven days ...incident charting will be completed. The weekly/ daily nursing notes will include the individual response to meds, any side effects and relevant lab values. 4. Incident charting includes any circumstances involving the client, which indicate an immediate or unexpected change of status. Some examples include ...injuries, special treatment procedures ... and self-abusive behaviors. 5. Summary documentation is directed at recording progress toward achieving the measurable treatment plan goal. Summary documentation should include ...Client's mental status, physical status, behavior in the therapeutic milieu, mood, affect, medication	V 512	evidence of appropriate stickers signifying patient safety precautions that must correspond with those precautions identified by the High Risk/High Alert Hand-Off and, as ordered by the patient's physician. Deficiencies noted will be immediately corrected. Staff not meeting these requirements will be addressed on a progressive disciplinary basis. All nursing staff with patient care responsibilities are being trained through inservice activities on these requirements. 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. Staff not meeting these requirements for use of the hand -off form and procedure will be addressed on a progressive disciplinary basis. **(b)(2) Date of Completion**: 02/18/2018 **(c) (2) Responsible Person**: Director of Nursing **(d) Monitoring procedure to ensure correction** (a)(2) During daily Administrator on Call rounds, the AOC will check the 15-minute check sheets for evidence of appropriate stickers signifying patient safety precautions that must correspond with those precautions identified by the High Risk/High Alert Hand-Off and, as ordered by the patient's physician. Deficiencies noted will be immediately corrected. The findings will be summarized at the Hospital's Morning Meeting of leadership staff. The findings will be aggregated and reviewed at the weekly PRTF PI Committee. A Governing Board Member will be a weekly participant to hear the results presented at this meeting. The findings, conclusions, recommendations, and actions 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.	

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V 512	Continued From page 113 compliance and response, appetite and intake, percent of weight gain or loss, grooming and hygiene, quality of sleep, nursing interventions, current nursing care being provided, and any restrictive interventions needed ...7. Staff will document the client's location on the observation sheet every 15 minutes ..." Review of a local "Police Department Incident Report" revealed the police were called on 01/01/2018 at 2156 to assist with an assault to MHT #10, property damage and ten missing persons listed as Resident #8 ([redacted] Resident #9 ([redacted] Resident #10 ([redacted] Resident #2 ([redacted] Resident #1 ([redacted] Resident #6 ([redacted] Resident #11 ([redacted] Resident #12 ([redacted] Resident #3 ([redacted] and Resident #7 ([redacted] A.1. Open medical record review on 01/09/2018 for Resident #1 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) on [redacted]/2017 with diagnoses of [redacted] Review of the intake assessment revealed the resident [redacted] Admission vital signs were [redacted] Review of the Psychiatrist Evaluation documented on [redacted]/2017 at 2050 revealed "[redacted]	V 512	**Root cause (contributing factor):** **3) Information of incoming patients and prior placements with other patients was not always known to the facility. History of patterns of elopement and history of violent behaviors were not always communicated.** (a)Part of the query of the intake assessment now compares prior placements of prospective residents to those residents currently in house. If there is evidence learned of a prospective resident having resided at the same facility of a current resident, a further inquiry regarding relationship between the two will be obtained and documented before accepting the new resident. Prospective residents with determined histories of conflict with a current resident or having affiliated with a current resident will be excluded from admission. All intake assessment staff are being trained through inservice activities on these requirements. 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. Staff not meeting these requirements will be addressed on a progressive disciplinary basis. **(b) Date of Completion**: Approved by the Governing Board 01/ 26 /2018 and now in place for PRTF unit **(c) Responsible Person**: Chief Executive Officer **(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 affiliation with a current resident. On a weekly basis, SBC, Charlotte will conduct	

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V 512	Continued From page 114 [redacted]" Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #1 had the following risk and history of violence: "[redacted] 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 the medical record revealed documentation of a [redacted] for Resident #1 on [redacted]/2017 from 1048-1053 for destruction [redacted], a [redacted] on [redacted]/2017 from 1628-1638 for [redacted], a [redacted] on [redacted]/2017 from 1810-1825 for [redacted], and a [redacted] on [redacted]/2017 from 2107-2122 for [redacted] Review of facility video recordings on 01/10/2018 of residential hallways on 01/1/2018, revealed Resident #1, fully dressed in [redacted] Review of the record revealed a nursing shift note dated 01/01/2018 at 2035 that recorded "[redacted] Record review revealed a 7pm-7am nursing note dated 01/01/2018 at 2100 that recorded "[redacted]	V 512	a PRTF Performance Improvement (PI)Committee meeting. A Governing Board 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. **Root cause (contributing factor):** **4)The treatment plans did not always reflect individualized patient information including elopement history, violence history, and strategies to prevent. An audit for same was not in place to identify deficient entries.** (a)(1) All staff with responsibility for completion of the treatment plan ae being instructed through inservice education on the requirement to include all patient information that will be necessary to formulate an effective initial treatment plan for the resident. Information shall include elopement and violence history, suicide precautions, and any precautions that may impact the resident's safety and the safety of other residents and staff. Compliance with this responsibility will be evaluated daily (M-F) as part of the Hospital's Morning Leadership meeting (see monitoring section for description). Deficiencies noted will be updated within one hour of discovery. Staff not meeting these requirements will be addressed on a progressive disciplinary basis. 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.	2/18/18

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V 512	Continued From page 115 [redacted] Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room [redacted] on 01/01/2018. 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 [redacted] Review of the Observation Sheet dated 01/02/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at [redacted] Review of the night shift notes recorded by MHT #16 revealed the resident was [redacted] (minutes). Resident physically attacked staff [redacted]" Review of the medical record on 01/09/2018 revealed no documentation of a nursing assessment in the record after the resident was returned from elopement. Review of the record	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. **(b)(1) Date of Completion**: 02/18/2018 **(c)(1) Responsible Person**: Director of Clinical Services 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 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. 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. 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. 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. **(b)(2) Date of Completion**: 02/18/2018 **(c) (2) Responsible Person**: Director of Clinical Services	2/18/18

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V 512	Continued From page 116 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 [redacted]. Note recorded that [redacted] Review of nursing note dated 01/02/2018 at 1430 revealed [redacted] Review of telephone orders dated 01/02/2018 not timed revealed orders to place Resident #1 on [redacted] for [redacted] and [redacted] and [redacted] upon return to facility. Review of physician orders dated 01/02/2018 at 2050 revealed a telephone order for [redacted] as needed for [redacted]. Review of a Case Management Note documented by the Director of Clinical Services (DCS), dated 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 [redacted]. Note recorded the DCS and the DON questioned client about any injuries, pain or other concerns. Note recorded the DCS set expectations for resident's return to the unit. Note recorded the client was assessed by a Registered Nurse (RN). Review of the Psychiatrist progress note dated 01/04/2018 at 1237 revealed [redacted]	V 512	**(d)Monitoring procedure to ensure correction** 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 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 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 Leadership Staff, Monday through Friday. 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 at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date.	

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V 512	Continued From page 117 [redacted] Review of a Health Incident Review Report for Resident #1 completed by RN #2 and dated 01/01/2018 recorded "[redacted] Review of the report revealed the date and time of the elopement was 01/01/2018 at 2155. Review of a Health Incident Review Report for Resident #1 completed by RN #4 on 01/02/2018 recorded "[redacted] Review of a Health Incident Review Report for Resident #1 completed by RN #5 and dated 01/02/2018 recorded "[redacted]	V 512	**Root cause (contributing factor):** **5) The prior CEO had erroneously communicated to staff to not involve the Police in patient situations.** (a) All Hospital staff are now receiving training specific to the 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 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. 100% of key events including restrictive interventions, aggressive acts of patients to patients 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 Police Dept. will occur. Staff not meeting these requirements after re-training will be addressed on a progressive disciplinary basis.	Meeting with Police 1/17/18 Trng and re-trng on policy completed 2/18/18

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V 512	Continued From page 118 [redacted] Review of the report revealed the date and time of the incident was 01/02/2018 at 1321. Review of the Medication Administration Record revealed no available documentation of [redacted] administered on 01/02/2018. Review of Restrictive Intervention documentation dated 01/02/2018 at 1321 revealed a physician order for [redacted] for resident [redacted] Restrictive intervention documentation revealed Resident #1 was placed in [redacted] on 01/02/2018 at 1321, then [redacted] at 1322 and [redacted] at 1342. Restrictive Intervention documentation revealed Resident #1 was administered [redacted] at 1326. Interview on 01/12/2018 at 1015 with RN #5 revealed Resident #1 was [redacted]. Resident #1 had a [redacted] Interview on 01/12/2018 at 1015 with RN #5 revealed Resident #1 was admitted to the 200 hall due to elopement risk. Interview revealed we [redacted] Interview revealed we	V 512	b) **Date of Completion:** Meeting with Charlotte Police Dept.: 01/17/2018 Completion of training on policy for all SBC Charlotte staff: 02/18/2018 **(c) Responsible person**: Director of Compliance/Quality/Risk **(d) Monitoring procedure to ensure correction** Compliance will be monitored as follows: A 100% review of key events including restrictive interventions, aggressive acts of patients to patients 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 contacted, when indicated. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 at each of their respective meetings. This process will continue as presented on a go-forward basis and has no end date.	

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V 512	Continued From page 119 [redacted]. Resident #1 said [redacted] 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 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) on [redacted]/2017 as [redacted] Review of the record revealed admission diagnosis included [redacted] Review of admissions information titled "Clinical Evaluation/Diagnostic Assessment" dated [redacted]/2017 recorded by [redacted] revealed the resident [redacted] Review revealed the resident has [redacted] Review revealed on [redacted]/2017 the resident [redacted] Review of a Comprehensive Psychosocial Assessment Tool documented by [redacted] on [redacted]/2017 (not timed) recorded the resident [redacted]." Further review of the "Admission Intake Assessment Form" dated 12/18/2017 stated Resident #2 had the following risk and history of violence: [redacted] Based on the medical record review	V 512	**Root cause (contributing factor):** **6) There was no prior experience of what evolved into a patient riot or actions to take** (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 report to assess if	2/18/18 all elements

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V 512	Continued From page 120 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 #2, fully dressed [redacted] Review of admission orders dated 12/19/2017 revealed the resident was placed on assault precautions with every 15 minute observation checks. Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room [redacted] on 01/01/2018. 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 "[redacted]:" (location not defined) from [redacted]; [redacted] "[redacted]"; [redacted] "[redacted]" (location not defined). Review of the night shift notes recorded by MHT #14 revealed the resident was returned from elopement and placed on every 15 minute room checks. The notes recorded that the resident was given an [redacted] and [redacted]. Review of nursing notes documented by RN #2 on 01/01/2018 at 1920 recorded the resident's [redacted] was [redacted] and [redacted] was given [redacted] Notes recorded "[redacted]"	V 512	the Riot Management plan was followed including if the Police were contacted, when indicated. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 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):** **7) The furniture in use at the hospital, to date, had never been stressed to the point of being broken.** (a) The desks that were broken by the residents and separate boards used to devise weapons were removed from the environment. Chairs containing the same design with slats that were broken off were reinforced with hardware (that, itself, cannot be compromised) to increase their strength and reduce the chance of being dismantled through the application of force.	1/23/18 Rounds in place 2/7/18 Prototype desk 2/18/18 Trng and re-trng of staff on assessing for furniture or equipment that may be damaged

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V 512	Continued From page 121 [redacted]." 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 the resident returned to the facility [redacted]. Notes recorded the resident was "[redacted]." Record review revealed the resident was [redacted]d and [redacted] upon return to the facility on 01/02/2018. Review revealed the resident was placed on [redacted] upon return. Review of nursing notes documented on 01/02/2018 at 1400 recorded "[redacted]." Review of a psychiatrist progress note dated 01/04/2018 at 1242 recorded the patient [redacted] Review of the notes revealed "[redacted]. ..." Review of Health Incident Review Report for Resident #2 completed by RN #2 and dated 01/01/2018 recorded [redacted]	V 512	A prototype desk has been devised that has solid 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 as a weapon. All staff with patient care responsibilities are being advised through inservice education that, when furniture or other objects are being broken by a patient to use as weapon, and such a weapon is 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 integrity of furniture in the patient care environment at the start of each shift and to remove and secure furniture that appears to have been compromised or that may pose a possible risk for being broken. In order to remain on the schedule, staff not in attendance for the inservice are required to receive 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 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 rounds in place as of: 01/23/2018 **(c) Responsible person:** Director of EOC	

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V 512	Continued From page 122 [redacted]." Review of the report revealed the date and time of the elopement was 01/01/2018 at 2155. Interview on 01/12/2018 at 1015 with RN #5 revealed Resident #1 was admitted to the 200 hall due to elopement risk. Interview revealed we [redacted] Interview revealed we [redacted] Resident #1 said [redacted] Interview revealed from that point forward Resident #1 and Resident #2 were not to be on the same hall together. 3. Open medical record review of Resident #11 revealed a [redacted] admitted to the PRTF on [redacted]0/2017 with [redacted], anger issues. Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #11 had the following risk and history of violence: "[redacted]." 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 #11, fully dressed in [redacted]	V 512	**(d) Monitoring procedure to ensure correction** Compliance with the corrective actions will be accomplished as follows: On a daily basis (M-F), the EOC Director will conduct rounds in all resident care areas to ensure that the furniture is secure, and that there is evidence of no 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 assess the integrity of all furniture in the PRTF patient care areas prior to the start of each shift. Any items that appear to have been compromised or that may pose a possible risk for being broken will be immediately removed from the environment and not returned until repaired or replaced. **Root cause (contributing factor):** **8) The medical record audit process was not capturing time/date omissions, assessments and re-assessments not documented, as required. Similarly, the performance improvement review process was not capturing the review for compliance with items including treatment plan content against patient precautions and re-assessments per expectation.** (a) All SBC Charlotte Hospital leadership staff with responsibilities within their departments for medical record documentation have been re-educated on the specific requirements for the medical record components including: but not limited to: (1) Dating/timing of orders within requirements (2) Frequency of documentation (3) Medications documented as ordered (4) Completion of assessments and reassessments per time requirements (5) Frequency of MD Progress Notes (6) Co-signature by MD after Seclusion and Restraint within 24 hours These items are in addition to those otherwise noted in this report.	2/18/18

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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 dated 01/01/2018 revealed the resident was assigned to Room [redacted] 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 "3[redacted]" from [redacted]; then "[redacted] from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted] Review of Night shift notes recorded by MHT #17 revealed "[redacted]." Review of notes at 2202 revealed "[redacted]." A nursing note by RN #1 on 01/02/2018 at 0000 recorded "[redacted]." Nursing notes documented by RN #5 dated 01/02/2018 at 1330 recorded "[redacted]." Notes at 2200 recorded [redacted]	V 512	All SBC Charlotte Hospital and Medical staff with responsibility for documentation have been reminded through meetings and written memoranda of the requirements for documentation, as delineated above. All SBC Charlotte Hospital leadership staff with responsibilities within their departments for medical record documentation have been re-educated on the medical record audit process and associated expectations for its completion. 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. **(b) Completion Date:** Re-education of Hospital and Medical Staff: 02/18/2018 Re-education of Hospital leaders on requirements: 01/31/2018 Initiation of intensified audits: 02/01/2018 **(c) Responsible Person:** Director of Compliance/Quality/Risk **(d)Monitoring procedure to ensure correction:** a) 100% audit of medical records will occur over the course of the week against medical records including compliance with: (1) Dating/timing of all orders (2) Frequency of documentation (3) Medications documented as ordered (4) Completion of assessments and reassessments per time requirements (5) Frequency of MD Progress Notes (6) Co-signature by MD after Seclusion and Restraint within 24 hours	

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V 512	Continued From page 124 [redacted] Notes revealed the resident had [redacted] and [redacted]. Notes revealed [redacted] medication was administered. Review of an LPN note dated 01/02/2018 at 0050 recorded "([redacted]." Review of the medical record on 01/10/2018 revealed no further documentation of a nursing assessment in the record after return from elopement on 01/01/2018. Review on 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded "[redacted] (LPN [redacted]." Review of a psychiatrist note recorded on 01/04/2018 at 1112 revealed "..[redacted]	V 512	**Root cause (contributing factor):** **9)False perception by staff that the police could not be called to assist when staff was not, otherwise, able to obtain control of the residents.** (a) All Hospital staff are now receiving training through inservice education specific to the 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 have to have approval by any off site administrative staff to do so (as previously noted in Attachment "E"). 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. 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. 100% of key events including restrictive interventions, aggressive acts of patients to patients 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	1/17/18 Meeting with police 2/18/18 Trng of all staff

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V 512	Continued From page 125 [redacted]. ..." 4. Closed medical record review of Resident #7 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted]. Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #7 had the following risk and history of violence: "[redacted]." 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 #7, fully dressed in [redacted]. 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 dated 01/01/2018 revealed the resident was assigned to Room [redacted] 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 "[redacted]" from [redacted] then "[redacted]" from [redacted] then "[redacted]" from [redacted] then "[redacted]" from [redacted]; then "[redacted]" from [redacted]. Review of Night shift notes recorded by MHT #13 revealed "[redacted]	V 512	the Charlotte Police Dept. will occur. Staff not meeting these requirements after re-training will be addressed on a progressive disciplinary basis. **(b) Date of Completion:** Meeting with Charlotte Police Dept.: 01/ 17 /2018 Completion of training on policy: 02/18 /2018 **(c) Responsible Person**: Director of Quality/Compliance/Risk **(d) Monitoring procedure to ensure correction** Compliance will be monitored as follows: A 100% review of key events including restrictive interventions, aggressive acts of patients to patients 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 contacted, when indicated. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 at each of their respective meetings.	

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V 512	Continued From page 126 [redacted]" Review of nursing notes documented by RN #1 dated 01/01/2018 at 2015 revealed the resident was easily agitated by peers and offered and refused prn (as needed) medication for agitation. Review of notes at 2202 revealed "[redacted]." A nursing note by RN #1 on 01/02/2018 at 0000 recorded "[redacted]." Review of nursing notes documented by an LPN dated 01/02/2018 at 0130 recorded "U[redacted]" Nursing noted [redacted]." Nursing notes documented by RN #5 dated 01/02/2018 at 1300 recorded "[redacted]." Notes at 2200 recorded [redacted]. Notes revealed the resident had [redacted] and [redacted]. Notes revealed [redacted] medication was administered. Review of the medical record on 01/10/2018 revealed no documentation of a nursing assessment in the record. Review on	V 512	**Root cause (contributing factor):** **10) 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 training that an indication of an impending elopement is that sometimes the resident is wearing multiple layers of clothes or dresses in sneakers or shoes when they normally do not do so. (c)Staff have been inserviced through classroom and written memoranda on their need to query residents 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 same. **I(b)Date of Completion:** Policy change implemented 02/18/.2018 Monitoring for compliance: 02/18/2018 **(c) Responsible person:** **Director of Nursing** **(d)Monitoring procedure to ensure correction** Compliance will be monitored as follows: 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 multiple layers of clothing. In addition, as part of 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	

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V 512	Continued From page 127 01/11/2018 revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded "([redacted]." Record review revealed the resident was discharged on [redacted]/2018. 5. Open medical record review of Resident #12 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted]. Review of a Comprehensive Psychosocial Assessment Tool completed by [redacted] on [redacted]2017 at 1703 revealed the patient had a "[redacted]." 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 [redacted]. 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 dated 01/01/2018 revealed the resident was assigned to Room [redacted] 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	V 512	clothing of patients. The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 at each of their respective meetings **Root cause (contributing factor):** 11) **Staff verbalized sometimes feeling "ill equipped" 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 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 contact and utilize the police department if a patient event escalates to one that cannot be otherwise handled by the staff on duty. 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. 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 that are standardly being asked include the following that are adapted from the Studer model: (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.	2/16/18 Revised rounds questions in place 3/31/18 addtional models of care in place

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V 512	Continued From page 128 was located at "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" from [redacted]. Review of Night shift notes recorded by MHT #16 revealed "[redacted]..." 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 and stated it was not accurate. The nurse stated it was documented that the resident was in the [redacted] at 2300, but [redacted] didn't return until 0000. "She couldn't have laid eyes on the resident. [redacted] wasn't back yet. I don't know why she documented that. It isn't correct." 6. Open medical review on 01/11/2018 of Resident #9 revealed a [redacted] admitted to the PRTF unit on [redacted] 2017 due to [redacted]	V 512	(3)Is there anyone that you want to recognize today as a team member that has been especially helpful 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? Three evidence-based programs have been identified to assist staff in gaining more effective skills in working with patients in the PRTF 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-collaborative-problem-solving-approach/). The second tool is from **Advanced Trauma Solutions** (advanced trauma.com). The last tool is the CARE program model that is supported by UNC Charlotte and Duke. All programs utilize a trauma-informed care approach but do not use a level system. **b) Date of completion**: Implementation of new patient care model 03/31/2018 Implementation of rounding using Studer Model tool: 02/16/2018 **c) Responsible person:** Chief Executive Officer **d)Monitoring procedure to ensure correction** 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? (2) Do you have the right amount of people to do your job effectively? If not, describe.	

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V 512	Continued From page 129 [redacted]. Review of the Intake Assessment dated [redacted]/2017 revealed Resident #9 was at risk for elopement with a history of "[redacted]." 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 [redacted]. Review revealed Resident #9 lived on the 200 hall. Review of a nursing note dated 01/01/2018 at 2120 revealed Resident #9 '[redacted]. 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 1800 to 2345 was "[redacted]." Review revealed a nursing note documented by RN #5 dated 01/02/2018 at 0010 that recorded "[redacted]". Review of a physician order dated	V 512	(3) Is there anyone that you want to recognize today as a team member that has been especially helpful 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? These rounds will occur daily (weekends covered by AOC). The findings of this review will be reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday. 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 at each of their respective meetings. **Root cause (contributing factor):** **12) Perception of staff of being "short staffed" on some shifts** 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 involvement, history of substance abuse disorder, and history of a conflict or affiliate relationship with a current resident of SBC Charlotte. 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,	1/5/18 staffing assessed as part of RCA 2/16/18 Revised rounds in place

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V 512	Continued From page 130 01/02/2018 revealed Resident #9 was placed on elopement precaution. 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 [redacted]" Review revealed Resident #9 stated "[redacted]." 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 [redacted] along with other peers. 7. Open medical record review on 01/10/2018 for Resident #10 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) from [redacted] /2017 with a diagnosis of [redacted]. Review of the nursing notes revealed Resident #10 arrived on the PRTF unit at 2030. Review of nursing notes revealed the resident was [redacted], with no complaints of pain or discomfort. Review of the nursing notes revealed the resident had old injuries noted to [redacted] Admission vital signs were [redacted]. Review of the intake assessment revealed the resident was currently [redacted]. Further review of the intake assessment revealed documentation of elopement risk related to the [redacted]	V 512	as appropriate to reduce their discomfort are being employed. Examples include calling in a PRN staff member or reallocating staff to the area where there is a perception of "short staffing". A daily review of staffing coverage for all shifts is now being reported to the Hospital's Morning Meeting of Leadership staff. Shifts out of compliance with staffing are addressed through PRN coverage or leadership assisting with any deficits in same. Whenever there is a patient event requiring a root cause analysis, the adequacy of staffing and competencies and qualifications of staff are assessed to determine if staffing might have been a factor in the occurrence or prevention of same. **(b) Date of implementation of all elements:** Rounds by CEO using Studer model: 02/16/2018 Daily review of staffing coverage and inclusion of staffing as a part of RCA discussion: 01/ 05/2018 **(c) Responsible person:** Director of Nursing **(d)Monitoring procedure to ensure correction** Staff's perceptions about being short-staffed are being monitored as follows: As part of the daily rounds made by the CEO, staff will be asked to answer the following questions: "Do you have the right amount of people to do your job effectively? If not, describe." These rounds will occur daily (evenings and weekends covered by AOC). On a daily basis, the Director of Nursing is reporting on compliance with staffing requirements for all nursing units. The findings from these activities are being reported at the Morning Meeting of Hospital Leadership Staff, Monday through Friday.	

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V 512	Continued From page 131 [redacted]. Further review of the "Admission Intake Assessment Form" dated [redacted]/2017 stated Resident #10 had the following risk and history of violence: "[redacted]." 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 [redacted]. Review of the record revealed a nursing note documented by RN #1 dated 01/01/2018 at 2045 that recorded "[redacted]." Review of the record revealed a note documented by RN #1 dated 01/01/2018 at 2202 that recorded "[redacted]." Review of the record revealed a note documented by RN #1 dated 01/02/2018 at 0000 that recorded "[redacted]." Review of an Observation Sheet dated 01/01/2018 revealed the resident was assigned to Room [redacted] on 01/01/2018. 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 [redacted]	V 512	The findings of compliance with staffing grids and 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 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. In addition to the above, The findings from all Root Cause analyses 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):** **13) S&R policy and procedure not consistently followed per requirements)** All nursing staff with responsibility for seclusion or restraint requirements are being apprised through inservice activity of the requirements specific to the associated policy and procedure. . 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. The policy and procedure for Seclusion and Restraint has been reviewed with the Medical Staff to ensure their compliance with the associated requirements. **b) Date of completion:** 02/18/2018 **c) Responsible person:** Director of Quality/Compliance/Risk	2/18/18

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V 512	Continued From page 132 [redacted]. Review of the Observation Sheet dated 01/02/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at '[redacted] Review of the night shift notes recorded by MHT #16 revealed the resident '[redacted]." 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 0010 that recorded [redacted]. Note recorded the resident was '[redacted]." Note recorded that [redacted]." Review of telephone orders dated 01/02/2018 not timed revealed orders to place Resident #10 on [redacted] for [redacted] and [redacted] and [redacted] upon return to facility. Review of a Case Management Note documented by the Director of Clinical Services (DCS), dated 01/02/2018 and signed as "Late Entry" on 01/03/2018 not timed revealed she met with the client, the Director of Nursing (DON) and the Milieu Manager (MM) after the resident was returned to the facility [redacted]. Note recorded the DCS and the DON questioned client about any injuries, pain or other concerns. Note recorded the DCS	V 512	**d) Monitoring procedure to ensure correction** 100% of episodes of Seclusion and Restraint will be monitored for compliance with requirements in accordance with the policy and procedure. 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. 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 at each of their respective meetings. **Root cause (contributing factor):** **14) Doors to Hallways were being propped open by staff at night, thereby allowing potential for unauthorized access to other patient hallways and increasing risk of patients intermixing inappropriately.** a) All hospital staff with patient care unit physical interaction are being instructed that the doors between units are not to be propped open. A policy and procedure has been developed to address this requirement. Attachment "K" delineates the policy and its associated requirements.	2/14/18 Follow up menu 2/18/18 Specific policy review with all staff.

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V 512	Continued From page 133 set expectations for resident's return to the unit. Note recorded the client was assessed by a Registered Nurse (RN). Review of the Psychiatrist progress note dated 01/04/2018 at 1249 revealed " ..[redacted]." Review of a Health Incident Review Report for Resident #10 completed by RN #1 and dated 01/01/2018 recorded "[redacted]." Review of the report revealed the date and time of the elopement was 01/01/2018 at 2155. 8. Open medical record review of Resident #8 revealed a [redacted] admitted to the PRTF on 10/26/2017 with[redacted]. Review of a Comprehensive Psychosocial Assessment Tool completed by a social worker on [redacted]/2017 at 1000 revealed the patient stated, "[redacted]." 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 dated 01/01/2018 revealed the resident was assigned to Room [redacted] on 01/01/2018. Review of an Observation Sheet dated 01/01/2018 revealed	V 512	A follow-up memorandum is being prepared and distributed to all staff to alert them that they are not to leave the doors open between units as this compromises the security of these units as well as failure to follow policy will lead to disciplinary action up to and including termination. **b) Date of completion:** 02/18/2018 **c) Responsible person:** Director of EOC d) **Monitoring procedure to ensure correction** Compliance with this requirement will be accomplished by daily random checks on each shift and for each patient care area with occupied patients by the Safety Officer per camera and direct view means. The findings from this review will be reported on a Monday through Friday basis at the Morning meeting (F, S, and Sunday results will be incorporated into Monday's report). The findings, conclusions, and actions will be forwarded to the Hospital's PRTF PI meeting, of which a Governing Board member is in attendance, the Quality/Performance Improvement Council, and the Governing Board at each of their respective meetings.	

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V 512	Continued From page 134 every 15 minute checks were documented from 0000 through 2345. Review revealed the resident was located at "[redacted]" at [redacted]; then "[redacted] from [redacted]; then "[redacted]" from [redacted]; then "[redacted]" at [redacted] then "[redacted] from [redacted]; then "[redacted]" from [redacted]. Review of Night shift notes recorded by MHT #13 revealed "[redacted] ..." Review of nursing notes documented by RN #1 dated 01/01/2018 at 2030 revealed the resident was involved in [redacted] and [redacted] Review of notes at 2202 revealed "[redacted]." A nursing note by RN #1 on 01/02/2018 at 0000 recorded "[redacted]." 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 "[redacted]	V 512		

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[redacted]." Review of a psychiatrist note dated 01/06/2018 at 1054 revealed "[redacted]. ..."

Review of a Health Incident Review Report for Resident #8 dated 01/01/2018 at 2155 revealed "[redacted] ..."

9. Closed medical record review of Patient #3 on 01/09/2018 revealed a [redacted] admitted to the PRTF on [redacted]/2017 as a [redacted]. Review of the record revealed the admission diagnosis was [redacted]. Review of a nursing note dated 01/01/2018 timed at 1031 revealed a blank "Nursing Shift Note." Review of a restrictive intervention on 01/01/2018 from 2002 to 2008 revealed Resident #3 was [redacted] from 2002 to 2008 because [redacted]" Review of a nursing note (not dated) and timed at 2145 revealed "[redacted]

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V 512	Continued From page 136 ..." Review of the Observation Sheet dated 01/01/2018 revealed from 1800-2345 Resident #3 was "[redacted]." Review of the MHT note on 01/01/2018 revealed "[redacted] ..." Review of a telephone physician order dated 01/02/2018 not timed revealed "[redacted] ..." 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 [redacted]. Notes recorded revealed Resident #3 was "[redacted] ..." Review of a "Therapy Services Note" written on 01/03/2018 at 1132 revealed "[redacted] ..." 10. Closed medical record review on 01/09/2018 of Resident #6 revealed a [redacted] admitted to the PRTF on [redacted]/2017 due to	V 512		

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V 512	Continued From page 137 severe behavioral problems and violence. Resident #6 was discharged [redacted] on [redacted]/2018. Review of the record revealed admission diagnoses included [redacted] Review of the Q-15 Minute Observation Sheet dated 01/01/2018 revealed Resident #6 lived on the [redacted] hall. 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 "[redacted]" ([redacted]) from [redacted]; and "[redacted]" from [redacted] Review of the night shift notes recorded by MHT #16 revealed the resident was "[redacted]". 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 [redacted]. Notes recorded the resident was [redacted]". [redacted]." Review of physician order dated 01/02/2018 revealed an order to place the resident on [redacted] and [redacted] and [redacted] upon return. Review of a nursing note documented by RN #1 dated 01/01/2018 at 2202 revealed resident "[redacted]	V 512		

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V 512	Continued From page 138 [redacted]. Review of nursing notes documented on 01/02/2018 at 0000 recorded resident returned to facility accompanied by police, no apparent injuries and was placed on elopement precautions. 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 [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) on [redacted]/2017 with diagnoses of [redacted]. Review of the intake assessment revealed the resident had a [redacted]. Further review of the intake assessment revealed documentation of homicidal risk and elopement risk related to the resident [redacted]. Record review revealed Resident #1 had a known history of elopement on admission and eloped from the facility on 01/01/2018. Admission vital signs were [redacted]. Review of the Psychiatrist Evaluation documented on 12/20/2017 at 2050 revealed [redacted]	V 512		

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V 512	Continued From page 139	V 512		

[redacted]" Review of the medical record revealed documentation of a [redacted] for Resident #1 on 01/02/2017 from 1321-1342 for [redacted]. Review of the Medication Administration Record revealed documentation of [redacted] administered on 01/05/2018 no time. Review of the Restrictive Intervention documentation dated 01/05/2018 at 2015 revealed a physician order for [redacted]. Resident #1 was [redacted] and [redacted]. Resident #1 was [redacted]. Restrictive intervention documentation revealed Resident #1 was placed in a [redacted] on 01/05/2018 at 2015 and released at 2040. Restrictive Intervention documentation revealed Resident #1 was administered [redacted] at 2025. Review of the medical record revealed a nursing note documented by RN #5 on 01/05/2018 at 2040 that recorded "[redacted]." Review of the medical record revealed documentation of a [redacted] for Resident #1 on 01/05/2018 from 2015-2040 for [redacted].

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V 512	Continued From page 140 Review of a nursing note documented by RN #5 at 2130 revealed "[redacted]." Review of nursing note documented by RN #5 revealed "[redacted]." Review of restrictive intervention documentation revealed Resident #1 was [redacted] on 01/05/2018 at 2224 after [redacted]. Resident #1 was [redacted]. Documentation revealed Resident #1 was [redacted] on 01/05/2018 at 2323. Review of an Observation Sheet dated 01/05/2018 revealed the resident was assigned to Room [redacted] on 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 [redacted]	V 512		

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V 512	Continued From page 141 [redacted]." Review of the night shift notes dated 01/05/2018 recorded by MHT #11 revealed "[redacted]." Review of physician orders revealed a telephone order dated 01/05/2018 at 2224 for "[redacted]." Review of the medical record revealed documentation of a [redacted] for Resident #1 on 01/05/2018 from 2224-2323 for [redacted]. Review of orders revealed a telephone order dated 01/06/2018 at 2224 "[redacted]." 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 "[redacted]." 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 dated 01/08/2018 at 1335 "[redacted]"	V 512		

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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 "[redacted]." 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 "[redacted]." 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 "[redacted]." Review of the report revealed the date and time of the incident was 01/05/2018	V 512		

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V 512	Continued From page 143 at 2224. 2. Closed medical record review of Resident #2 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) on [redacted]/2017 as [redacted] Review of the record revealed admission diagnosis included [redacted] 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 [redacted]/2017 recorded by a [redacted] revealed [redacted] Review revealed the resident has [redacted] Review revealed on [redacted]. The resident was [redacted] Review of a Comprehensive Psychosocial Assessment Tool documented by a [redacted] on [redacted]/2017 (not timed) recorded the resident [redacted]." Review of admission orders dated [redacted]/2017 revealed the resident was placed on [redacted] with every 15 minute observation checks. Review of a nursing note documented by RN #5 on 01/05/2018 at 2030 revealed the resident [redacted] because [redacted]. Notes recorded [redacted]	V 512		

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V 512	Continued From page 144 [redacted]. Review revealed an order was received for [redacted] and the medication was not administered because the resident [redacted]. Review of the emergency restrictive intervention revealed the resident remained [redacted] from 2015 through 2040. Nursing notes recorded by RN #5 on 01/05/2018 at 2130 recorded [redacted] Notes recorded the resident [redacted] Notes revealed the legal guardian was notified. Review of physician's orders revealed a telephone order dated 01/05/2018 (not timed) to [redacted]. Review of an Observation Sheet dated 01/05/2018 the resident was in [redacted] at 1530 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 "[redacted]" 3. Open medical record review of Resident #8 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted] Review of a Comprehensive Psychosocial Assessment Tool completed by a [redacted] on [redacted]/2017 at 1000 revealed the patient stated, "[redacted]." Record review revealed Resident #8 had a known history of elopement on admission and eloped from the facility on 01/01/2018. Review of	V 512		

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V 512	Continued From page 145 admission orders revealed the resident was placed on every 15 minutes observation. Review of nursing notes documented by RN #5 dated 01/05/2018 at 2200 revealed [redacted]." Review of a Health Incident Review Report for Resident #8 dated 01/05/2018 at 2030 revealed "[redacted]..." 4. Closed medical record review of Resident #3 on 01/09/2018 revealed a [redacted] admitted to the PRTF on [redacted]/2017 as a [redacted]. Review of the record revealed the admission diagnosis was [redacted]. 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 Note" written on 01/03/2018 at 1132 revealed "[redacted]	V 512		

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V 512	Continued From page 146 [redacted]..." Review of a nursing note dated 01/05/2018 at 2330 revealed "..[redacted]..." Review of a nursing note by RN #5 on 01/05/2018 at 2200 revealed "[redacted]..." Review of physician orders dated 01/05/2018 at 0320 revealed "[redacted]" Review of a nursing note dated 01/06/2018 at 0130 revealed "[redacted]..." Review revealed Resident #3 was discharged to local police custody and did not return to the facility. Review of a Health Incident Review Report dated 01/05/2018 at 2030 revealed "[redacted]." 5. Review on 01/11/2018 of the medical record of Resident #9 revealed a [redacted] admitted on [redacted]/2017 to the facility due to [redacted] Review of the Intake Assessment dated [redacted]/2017 revealed Resident #9 was at risk for elopement with a	V 512		

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V 512	Continued From page 147 history of "[redacted]." Record review revealed 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 [redacted]. Review revealed Resident #9 lived on the [redacted] hall. Review of a physician order dated 01/02/2018 revealed Resident #9 was placed on [redacted]. Review of a nursing shift note dated 01/05/2018 at 2200 revealed Resident #9 was [redacted] Resident #9 was [redacted] Resident #9 was [redacted] Review on 01/11/2018 of the Health Incident Review Report dated 01/05/2018 revealed Resident #9 [redacted] Additional review revealed Resident #9 was [redacted]. 6. Open medical record review on 01/10/2018 for Resident #10 revealed a [redacted] admitted to the Psychiatric Residential Treatment Facility (PRTF) [redacted] /2017 with a diagnosis of [redacted] 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 revealed Resident #10 arrived on the PRTF unit at 2030. Review of nursing notes revealed the resident was [redacted], with no	V 512		

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V 512	Continued From page 148 complaints of pain or discomfort. Review of the nursing notes revealed the resident had old injuries noted to [redacted]. Admission vital signs were [redacted]. Review of the intake assessment revealed the resident was currently [redacted]. Further review of the intake assessment revealed documentation of elopement risk related to the resident [redacted]. Review of nursing notes dated 01/05/2018 at 2200 revealed Resident #10 "[redacted]." Review of telephone order dated 01/05/2018 not timed revealed an order to "[redacted]." Review of a 7pm-7am nursing shift note dated 01/06/2018 at 0130 revealed "[redacted]f." Review of an Observation Sheet dated 01/05/2018 revealed the resident was assigned to Room [redacted] 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 "[redacted]. Review of the night shift notes recorded by MHT #16 revealed the resident was "[redacted]." Review of an Observation Sheet dated 01/06/2018, 01/07/2018 and 01/08/2018 revealed the resident was assigned to Room [redacted] on 01/06/2018, 01/07/2018 and 01/08/2018. Review	V 512		

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V 512	Continued From page 149 of the Observation Sheet dated 01/06/2018, 01/07/2018 and 01/08/2018 revealed every 15 minute checks were recorded from 0000 through 2345. Review revealed the resident was located at "[redacted]. Review of a Health Incident Review Report completed by RN #1 and dated 01/05/2018 recorded "[redacted]." Review of the report revealed the date and time of the incident was 01/05/2018 at 2030. 7. Open medical record review of Resident #12 revealed a [redacted] admitted to the PRTF on [redacted]/2017 with [redacted] Review of a Comprehensive Psychosocial Assessment Tool completed by a [redacted] on [redacted]/2017 at 1703 revealed the patient had a "[redacted]." Record review revealed Resident #12 had a known history of elopement on admission and eloped from the facility on 01/01/2018. Review of admission orders revealed the resident was placed on every 15 minutes observation. Review of an Observation Sheet dated 01/05/2018 revealed every 15 minute checks were documented from 0000 through 2345. Review revealed the resident was located at "[redacted]" from [redacted]; then "[redacted]" from [redacted]; then "[redacted] from [redacted]. Review of Night shift notes recorded by MHT #16 revealed "[redacted].	V 512		

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V 512	Continued From page 150 [redacted]..." Review on 01/16/2018 at 1435 of the 100, 200, and 300 hall video monitor recordings for 01/05/2018 revealed: Residents [redacted] wearing bandanas, double layers of clothing and / or jackets between 2010 through 2107 . 2010: Residen[redacted] 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 Residen[redacted] ([redacted]) from the 100 hall back to the 200 hall. The 100 to 200 hall door was opened and Resident[redacted] charged the door. MHT #18 and #26 prevented Resident[redacted] from entering the 200 hall. 2015: RN #27 opened the 200/100 hall door and Residen[redacted] charged the door and entered the 200 hall. MHT #12, #16, and #26 entered the 200 hall with the residents. 2016: Resident[redacted] were escorted back from the 200 hall back to the 100 hall. 2020: Residen[redacted] was in a manual hold by MHT #18 on 200 hall. Resident[redacted] was pacing the 200 hall and kicking the 200 hall doors. MM #8 was walking around with Resident[redacted] 2024: Resident[redacted] 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. 2029: Resident[redacted] was escorted from the 200 hall back to the 100 hall 2032: Resident[redacted] was placed in a manual hold by MM#8 on 200 hall. RN #1 was observing the	V 512		

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[redacted] hold. Resident [redacted] was escorted back to the 100 hall from the 200 hall by MHT #16 and #17.
2032: Resident [redacted] 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 [redacted] charged the door to the 200 hall and entered the 200 hall from the 100 hall.
2034: MHT #18 released Resident [redacted] from a [redacted] hold in the 200 hallway.
2035: Resident [redacted] walked towards MM#8 who was manually holding Resident [redacted] on the 200 hall. MHT #18 placed Resident [redacted] in a [redacted] hold. LPN #6 entered the 200 hall from the 100 hall and Resident [redacted] charged the door and entered 200 hall.
2035: Resident [redacted] escorted from 200 hall back to the 100 hall by LPN #6. Resident [redacted] kicked MHT#18 who was holding Resident [redacted]
2036: Resident [redacted] was released from a manual hold on the 200 hall.
2037: Resident [redacted] walked toward Resident [redacted] who was being manually held by MM#8 on the 200 hall.
2039: Resident [redacted] was in the 100 hall dayroom and pulled a wooden board from a chair and went into the 100 hallway. LPN #6 escorted Resident [redacted] from the 200 hall back to the 100 hall.
2040: MHT #11 took the wooden board from Resident [redacted] and placed it in the bin closet on the 100 hall. MHT #16 escorted Resident #[redacted] from the 200 hall back to the 100 hall.
2041: Resident [redacted] kicked the window in the 100 hall dayroom multiple times.
2042: Resident [redacted] entered the 100 hall dayroom with a wooden board and was hitting the window with the board. Resident [redacted] was given the

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V 512	Continued From page 152 wooden board by Resident [redacted] and also hit the window. Review revealed no staff were present at this time. 2043: Resident [redacted] had a chair from the 100 hall dayroom and was charging the 100/200 hall door with the chair. 2045: Resident [redacted] had a DVD and was attempting to cut his arm with the broken DVD in the 100 hall dayroom. MHT #17 took DVD away from Resident [redacted] 2047: Resident [redacted] escorted back to 100 hall from 200 hall. In the 100 hall dayroom Resident [redacted] got a piece of a wooden board from the chair and entered the 100 hall. 2049: A piece of wooden board was removed from Resident [redacted] by MHT #26 and locked in the bin room. 2053: Three emergency medical service (EMS) personnel arrived on the 200 hall and went to the 100 hall. 2054: Resident [redacted] was released from a manual hold. 2055: Six police officers arrived on the 200 hall and went to the 100 hall. 2058: Five additional police officers brought to the 200 hall by AS #22. (Total 11 police officers and 3 EMS personnel) 2101: Resident [redacted] entered the 300 hall when the door was opened by LPN #6 to let medics through. Resident [redacted] entered the 200 hall from the 100 hall when door was opened for police to enter. 2106: Resident [redacted] hit MHT #26 and was taken down and arrested by police officers. 2107: Resident [redacted] entered the 200 hall from the 100 hall when the door was opened to let police leave. Telephone interview on 01/09/2018 at 1015 with RN #3 revealed a second incident occurred on	V 512		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE	1715 SHARON ROAD WEST 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 512	Continued From page 153 01/05/2018. The nurse reported the "same group (residents from 01/01/2018 incident) started tearing up furniture. The nurse was told that the residents were "Targeting male staff. I was told to go to the 300 hall. Three female residents got in my face and a male tech intervened and got me off the unit." The nurse reported three resident were arrested for assaulting police and staff. The nurse stated a staff member was injured and there were several nurses on medical leave currently. The nurse stated there were few male staff left and that there was a resident that was considered "King of the roost on PRTF" that was discharged prior to the incident on 01/01/2018. RN #3 stated it was a "gang like effort to have a new Kingpin. They had been plotting for some time. They pick off male staff to reduce the force." RN #3 stated "It's not safe for kids, staff or the general community." Interview on 01/11/2018 from 0955-1035 with RN #1 revealed "I can't remember what happened on 01/05/2018. Resident in fight involved 2 boys on 100 hall, 1 girl from 300 hall. Occurred on individual halls. Couple of residents got arrested. I'm really sleepy and can't remember right now. Had enough staff. Don't recall any holds. 2 boys in fight on 200 hall. Name (Resident [redacted]) and Name (Resident [redacted]) in fight were on same hall I think. I don't remember who called police. I called Name (RN #5) and told her about the fights and 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 [redacted]) became aggressive towards the police and w[redacted]s arrested. Took Name (Resident [redacted]) out but brought back in. Took Name (Resident[redacted] 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	V 512		

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V 512	Continued From page 154 "Yes". Interview on 01/11/2018 from 1120-1245 with MHT #15 revealed on 01/05/2018 she was in the rec room with the 200 hall. Interview revealed "I knew something going on. Trying to transition back they said 'hold on'. Name (Resident [redacted] having fit to get back to 200. Ask to use bathroom. Name (Resident [redacted] goes back to 200 doesn't return, ends up on 100 hall, unknown how. Name (resident [redacted] and Name (resident [redacted]) come back to bathroom. Something going on, bust way back to 300 hall, leave them there. Seven residents with 2 MHT's. Quiet after all over with. Name (resident [redacted]) had IM (injection), removed to quiet room. All clear to return after police left the premises. If Name (resident [redacted]) acting out, all others join in." Interview on 01/16/2018 at 1640 with MM #8 revealed he was working on 01/05/2018 when there was another incident on the PRTF units. The staff member stated there was more of a nursing presence on 01/05/2018 and the recreational therapist was also present. Interview revealed MHT #10 was on "light duty" from an injury he received on 01/01/2018 when Resident [redacted] punched him in the ear. MM #8 reported "There was something going on every hall. I don't think it was planned. It was an impromptu plan developed after it started. I had not received an information that the residents planned to elope on 01/05/2018." Additional interview on 01/17/2018 at 1310 with MM#8 revealed he worked 1500-2300 on 01/05/2018. Interview revealed 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	V 512		

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V 512	Continued From page 155 the door. Interview revealed Resident #2 was programming on the 100 hall. Interview revealed MM#8 and the treatment team decided earlier in the day that Resident [redacted] could program on the 100 hall for one hour. Interview revealed this decision was based on Resident [redacted] displaying positive behavior earlier in the day. Interview revealed if a resident was going to program on a different hall then where they lived it was usually discussed in shift report. Interview revealed MM#8 was called out of shift report so he did not know if Resident [redacted] programming on the 100 hall for one hour was discussed. Interview revealed the "long-term goal" was to get Resident [redacted] on the 100 hall. Additional interview on 01/17/2018 at 1640 with MM #8 revealed several of the residents had bandanas on 01/05/2018. MM #8 stated "They shouldn't have had them. Bandanas are not on the approved clothing list. Some were bandanas, some of them were makeshift. Some were ripped t-shirts made into bandanas. Resident [redacted] had a real bandana." Interview on 01/17/2018 at 0930 with LPN #6 revealed she was scheduled to work 0700 to 1930 on 01/05/2018. Interview revealed LPN #6 stayed past 1930 on 01/05/2018 because during shift report she was called to the 100 hall. Interview revealed RN #1 was the only nurse assigned to 100, 200, and 300 hall from 1900 to 2300. Interview revealed LPN #6 went to the 100 hall when the Code GEAR was called and escorted Resident [redacted] back to [redacted] room on the 200 hall. Interview revealed LPN #6 did not know why Resident [redacted] was on the 100 hall instead of the 200 hall. Interview revealed "I would have never put (Resident [redacted] and (Resident [redacted]) on the same hall." Interview revealed when LPN #6 opened the door to the 200 hall Resident [redacted] and multiple other residents from the 100 hall charged	V 512		

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V 512	Continued From page 156	V 512		

the door and entered the 200 hall. Resident [redacted] was put in a manual hold on the 200 hall. Interview revealed Resident [redacted] was on the 200 hall pacing and kicking doors. Interview revealed "there was not enough staff to put (Resident [redacted] and (Resident [redacted] in a manual hold." Interview revealed residents had been "ranting and raving" about eloping after the 01/01/2018 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 on 01/05/2018 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 Resident [redacted] an injection "she (RN #1) got nervous and dropped the injection, so we wasted it." Interview revealed residents also pulled out wooden boards and staff members were hurt including LPN #6. 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 01/05/2018 lasted about an hour. Interview revealed "once the police came and residents realized they were outnumbered, they calmed

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V 512	Continued From page 157 down." Interview revealed LPN #6 was afraid for her safety and during this incident it was not a safe environment for staff or residents. Interview on 01/17/2018 at 1150 with MHT #26 revealed he worked on the 100 hall on 01/05/2018 from 1700-2200. Interview revealed he was not scheduled to work on 1/05/2018 but was called into work. Interview revealed MHT #26 noticed some residents were wearing bandanas and double layers around 1800. Interview revealed MHT #26 did not know where residents had gotten bandanas, but bandanas were not allowed. Interview revealed MHT #26 did not remove bandanas from residents. Interview revealed on 01/05/2018 around 2000 residents from the 100 hall charged the 200 hall door when it was opened to escort Resident [redacted] from the 100 hall to the 200 hall. Interview revealed MHT #26 stayed on the 100 hall with the remaining 100 hall residents that had not charged the door. Interview revealed MHT #26 was attempting to deescalate residents on the 100 hall and get them away from the 100/200 hall door. Interview revealed some residents on the 100 hall had a DVD and were self-harming. Interview revealed MHT #26 took the DVD's from the residents and locked them in the bin closet. Interview revealed Resident [redacted] had a wooden board with a nail in it and MHT #26 took away the wooden board and it was put in the bin closet. Interview revealed MHT #26 then went to the 200 hall to help with manual holds. Interview revealed MHT #26 put Resident [redacted] in a manual hold to prevent Resident [redacted] from kicking another staff member. Interview revealed MHT #26 released Resident [redacted] when he was calm and the police arrived shortly after that. Interview revealed this incident could have been prevented if Resident [redacted] and Resident [redacted] were not put on the same hall	V 512		

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V 512	Continued From page 158 together. Interview revealed MHT #26 did not know why Resident [redacted] was on the 100 hall. MHT #26 stated "I did not feel safe that night." Interview revealed there was not enough staff to keep residents and staff safe that night. Interview on 01/17/2018 at 1215 with MHT #28 revealed she was scheduled to work 1900 to 0730 on 01/05/2018. Interview revealed MHT #28 was scheduled on the 200 hall and when she arrived to work she went to the recreation room where the 200 hall residents were. Interview revealed around 1930 on 01/05/2018 MM#8 radioed to MHT #28 to bring Resident [redacted] to the 100 hall to program for one hour. Interview revealed MHT #28 brought Resident [redacted] to the 100 hall and then went back down to the recreation room. Interview revealed MHT #28 did recall hearing a Code Black called overhead during her shift. Interview revealed usually if a resident was going to program on a different hall than where they lived it was discussed in shift report. Interview revealed MHT #28 did not remember if Resident [redacted] programming on the 100 hall was discussed. Interview revealed "I do what I am told, (MM#8) told me to bring (Resident [redacted] to the 100 hall, so I did." Interview on 01/17/2018 from 1435-1450 with MHT #12 (Mental Health Technician) revealed he was also working the 7p-7a shift on 01/05/2018. Interview revealed "the residents decided to elope. Name (resident [redacted]) was on the 100 hall." Interview revealed the staff tried to keep the residents on the hall. Interview revealed "kids on the hall had plan to elope on 01/05/2018. Interview revealed some of the residents did have on bandanas or make shift bandanas. Interview revealed the residents should not have bandanas in their rooms as they are associated with gangs.	V 512		

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V 512	Continued From page 159 Interview revealed the residents' personal belongings should be checked every night while the residents were sleeping. The room checks should be documented on the hygiene check sheets. Interview on 01/11/2018 at 1645 with MHT #14 revealed she was in the recreation room with the 200 hall on 01/05/2018 at 1930 with MHT #15 and MHT #28. Interview revealed she didn't believe all the 200 hall residents were in the recreation room. Interview revealed MHT #28 escorted Resident [redacted] and Resident [redacted] back upstairs to the 200 hall to use the bathroom. Interview revealed she and MHT #15 never received clearance to transition the 200 hall back to the unit and remained in the recreation room from 1930-2300. Interview revealed she saw 8-10 police officers come downstairs with AS #22 and walked towards the therapist offices. Interview revealed the 200 hall residents were given their medications and returned to their rooms. Interview on 01/11/2018 from 1315-1430 with MHT #16 revealed the incident on 01/05/2018 occurred on the 200 hall. Interview revealed Resident [redacted] and Resident [redacted] were supposed to be separated, but MHT #28 was told Resident [redacted] was programming on the 100 hall, so she walked [redacted] to the 100 hall from the rec room. Resident [redacted] ran to room 102. Interview revealed the residents on the hall were wearing layered clothes and bandanas. Interview revealed the staff overheard Resident [redacted] tell Resident [redacted] "bout to be a show." Resident [redacted] was removed from the hall for a visit. Interview revealed the staff asked Resident [redacted] what "bout to be a show" meant and she said "planning to elope." MM #8 passed through the hallway. Interview revealed	V 512		

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V 512	Continued From page 160 "Once out of room MM #8 told Resident[redacted] to go back to 200 hall room. Once Resident[redacted] back on 200. Resident[redacted] tried to push me to get the door open. Resident[redacted] ran through everybody. MHT #18 and Resident[redacted] trip into room 207. MHT #18 safety hold on Resident[redacted] Resident[redacted] kicking the door. MHT #12 and Rec Therapist standing in the 207 doorway. Resident[redacted] stating 'Y'all have my brother, you need to let him go.' LPN #6 pulls medication and administers to Resident[redacted] while in proper hold. MHT #17 comes in. MHT #17 and RN #27 try to get Resident[redacted] back to 100. Resident[redacted] refused to go back to 100 hall. Doors shut everyone safe. Name (RN #1) waving shot while mouthing to 'I got to give him (resident[redacted]) a shot'. Resident[redacted] hears RN #1 and tells Resident[redacted] and sets[redacted] off after[redacted] had been calmed by MM #8. Resident[redacted] goes back to 100 hall, door won't shut, and boys pulling from one side, staff pulling from the other side, boys overpowered the staff. Almost all the boys came to 200 hall. Free for all, kicking, MHT #12 has Resident[redacted] in hold with MM #8 in hall. Guys trying to get to Resident[redacted] in hold. Resident[redacted] calmed down. Smacked nurses phone out of hand. Took almost 1 hour. Resident[redacted] is severe diabetic. While in hold Resident[redacted] said 'I can't breathe'. Bargained with the boys to return to 100 hall. Boys walked off and went back to 100. RN #27 monitoring Resident[redacted], pulling off layers of clothing, sick almost passing out. Hold ceased." Interview revealed the staff are expected to follow the '777' rule for resident clothing, meaning 7 pants, 7 shirts, 7 underwear, 7 socks, etc. Interview revealed LPN #6 notified RN #5 and AS #21, then she calls 911 for police assistance. Interview revealed "Resident[redacted] had a "weapon" (piece of board with nails broken off table) and was arrested. Resident[redacted] busted through the police and ran. [redacted] was arrested.	V 512		

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V 512	Continued From page 161 Resident [redacted] kicked the police officer and [redacted] was arrested. Interview revealed there had been no change in staffing on the units since the incidents and re-training on gears/de-escalation. Interview revealed the administrative staff met with them for 2 hours at the beginning of their 7pm-7am shift on 01/10/2018 to review concerns. Interview revealed the meeting information needed to be more in depth. Interview revealed the PRTF unit was not any safer because nothing had changed. Interview revealed some identified safety issues include the "new medication pass process, doors between residents' hall being held or propped open and activity coming in." Interview on 01/17/2018 at 1540 with AS #23 revealed she had stayed late on 01/05/2018 to speak to staff about the 01/01/2018 incident. Interview revealed AS #22 and #23 were interviewing staff when they heard a Code Purple called. Interview revealed they looked at the cameras and saw staff need help. Interview revealed "I called the administrators who said to call the police, so I did." C. Video review on 01/17/2018 at 1640 of the 100/200/300 halls revealed facility staffs failure to secure doors between twelve bed PRTF halls to promote supervision of residents and safe care. 01/03/2018 at 0000 the 100/200 hall door was propped open with a door magnet. 01/06/2018 at 0129 the 200/300 hall door was propped open with a door magnet and MHT (Mental Health Technician) #12 and #17 were sitting in the 200 hall way. 01/06/2018 at 0130 the 100/200 hall door was propped open with a door magnet and MHT #15 and #28 were walking in the hallway. 01/08/2018 at 0156 the 100/200 hall and the	V 512		

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V 512	Continued From page 162 200/300 hall door were propped open with a door magnet and MHT #28 was sitting in the 200 hall. 01/10/2018 at 2000 the 100/200 hall and 200/300 hall door were closed. 01/11/2018 at 0052 the 100/200 hall and the 200/300 hall door were closed. 01/11/2018 at 0300 the 100/200 hall and the 200/300 hall door were closed. 01/13/2018 at 0158 the 100/200 hall door was propped open with a door magnet. 01/16/2018 at 2000 the 100/200 hall and 200/300 hall door were closed. 01/17/2018 at 0050 the 100/200 hall and 200/300 hall door were propped open with a door magnet. Interview on 01/11 2018 at 1645 with MHT #14 revealed doors on the PRTF units are propped open to the magnets after the residents are asleep. 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." Interview on 01/17/2018 at 1215 with MHT #28 revealed the 100/200 and 200/300 hall doors were usually left open during 0000-0500 hours while the MHT's completed chores and residents were asleep. Interview revealed "doors are left open to get chores done faster." Interview	V 512		

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V 512	Continued From page 163 revealed the doors leading to the main corridor or outside were not left open. Interview revealed MHT #28 went to a crisis management meeting on 01/16/2018 "we were told not to leave doors open." NC00134720; NC00134922; NC00134623; NC00134785; NC00134699; NC00134620; NC00134829; NC00134595; NC00134588	V 512		

STRATEGIC BEHAVIORAL CENTER
POLICY AND PROCEDURE MANUAL

DEPARTMENT: Nursing Services		**SUBJECT: Maintenance of Integrity of Patient hallways and units**	
POLICY AND PROCEDURE: Transitions 1600.64		**Page 1 of 2**	
FUNCTIONAL AREA: Nursing		**REFERENCES:**	
EFFECTIVE DATE: 01/2018		**APPROVED BY: GOVERNING BOARD 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.
6. 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:

DEPARTMENT: Nursing Services		**SUBJECT: Maintenance of Integrity of Patient hallways and units**	
POLICY AND PROCEDURE: Transitions 1600.64		**Page 2 of 2**	
FUNCTIONAL AREA: Nursing		**REFERENCES:**	
EFFECTIVE DATE: 01/2018		**APPROVED BY: GOVERNING BOARD 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.