MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: U9SQ11

		PART 1-	TO BE COMPL	ETED BY T	HE STA	TE SURVEY AGENCY		Facility ID: 9429360113
MEDICARE/MEDICA (L1)	AID PROVIDE	R NO.	3. NAME AND AD			ER-CHARLOTTE	4. TYPE OF ACT	TION: <u>6 (</u> L8)
2.STATE VENDOR OR	MEDICAID NO	n	(L4) 1715 SHARO			ER-CHARDOTTE	1. Initial	2. Recertification
(L2)		·	(L5) CHARLOTT			(L6) 28210	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE C	CHANGE OF O	WNERSHIP	7. PROVIDER/SU	PPLIER CATEGO	ORY	<u>06</u> (L7)	7. On-Site Visit	9. Other
(L9)			01 Hospital	05 HHA	09 ESR	D 13 PTIP	8. Full Survey A	iter Compiaint
6. DATE OF SURVEY	02/03/		02 SNF/NF/Dual	06 LAB	10 NF	14 CORF	FISCAL YEAR ENI	DING DATE: (1.25)
 ACCREDITATION S[*] Unaccredited 		_1 (L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray	11 IMR		TIBOTE TEAKEN	DING DATE: (L35)
2 AOA	1 TJC 3 Other	970. b	04 SNP	08 OPT/SP	12 RHC	16 HOSPICE		
11LTC PERIOD OF CE	RTIFICATION		10.THE FACILITY	IS CERTIFIED A	AS:			
From (a):			X A. In Complian			And/Or Approved Waivers Of		ements:
To (b):		,	Program Re Compliance			2. Technical Personnel		
12. Total Facility Beds		(L18)	•	ceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical I VF) 8. Patient Ro	
•		(===,				5. Life Safety Code	9. Beds/Roo	
13.Total Certified Beds		(L17)		pliance with Progr nts and/or Applie		* Code: A*	(L12)	
14. LTC CERTIFIED BEI	D BREAKDOW					15. FACILITY MEETS		
18 SNF	18/19 SNF	19 SNF	ICF	IMR		1861 (e) (1) or 1861 (j) (1):	YES (L15)	
(L37)	(L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AG	ENCY REMA	RKS (IF APPLICA)	BLE SHOW LTC CAL	NCELLATION D	ATE):			
A licensure complair	nt investigatio	n was conducted	January 31, 2017 tl	hroguh Feburar	v 3, 2017.	A deficiency was cited under	10 NCAC 27G 1902	(h) Staffing
NC00123945, NC00)123747, NC(00123722, NC00	123717, NC001242	77, NC001244	71, NC001	12453		(o) otaling.
17. SURVEYOR SIGNA	TURĘ.		Date:			18. STATE SURVEY AGENCY	APPROVAL	Date:
<u> </u>			02	2/27/2017	7.10			
-	PAR	T II - TO BE C	COMPLETED B	Y HCFA REC	(L19) GIONAL	OFFICE OR SINGLE S	TATE AGENCY	(L20)
19. DETERMINATION				PLIANCE WITH		21. 1. Statement of Finar	ncial Solvency (HCFA-2:	572)
X_ 1. Facility i	is Eligible to Par	ticipate	RIGHT	TS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Str	nt (HCFA-1513)
	is not Eligible					5. Boll of the Above	· .	
		(L21)						
22. ORIGINAL DATE		23. LTC AGREEM	ENT 24.	LTC AGREEME	ENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION	4	BEGINNING	DATE	ENDING DATE	Ε	VOLUNTARY 00	INVOLU	INTARY
						01-Merger, Closure	05-Fail to	Meet Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburse		Meet Agreement
25. LTC EXTENSION D	DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>	
		A. Suspension	of Admissions:		ĺ	04-Other Reason for Withdrawal	07-Provi	der Status Change
	(L27)	D D 10		(L44)			00-Activ	re
	, ,	B. Rescind Sus	spension Date:					
28. TERMINATION DAT	TC.	20	D. TELEVISION CONT. DAVIS	(L45)				
26. TERMINATION DA	IE.	29.	INTERMEDIARY/C	ARRIER NO.	1	30. REMARKS		
			00000					
		(L28)			(L31)			
31. RO RECEIPT OF CM	IS-1539	32.	DETERMINATION (OF APPROVAL I	DATE			
		(L32)			(L33)	DETERMINISTICAL APPR	OVAT	F-5
		(202)			ردسا	DETERMINATION APPR	KUVAL	

CENTER R MEDICARE & MEDICAID SERVICES

						TE SURVEY AGENCY		ID: U9SQ11
			T			IE SURVEY AGENCY	1	Facility ID: 9429360113
MEDICARE/MEDICA	AID PROVIDER NO.		3. NAME AND AD			ER-CHARLOTTE	4. TYPE OF ACTIO	ON: <u>6 (</u> L8)
(L1) .	MEDICARDNO		(L4) 1715 SHARO			ER-CHARLOTTE	1. Initial	2. Recertification
2.STATE VENDOR OR 1 (L2)	MEDICALD NO.		(L5) CHARLOTT		.51	(L6) 28210	3. Termination	4. CHOW
			(L3) CHARLOTT	E, NC			5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE C	HANGE OF OWNE	RSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>06</u> (L7)	8. Full Survey Afte	er Complaint
(L9)			01 Hospital	05 HHA	09 ESR	D 13 PTIP	o. Yun durvey Arte	a Complaint
6. DATE OF SURVEY	02/03/2017	. ,	02 SNF/NF/Dual	06 LAB	10 NF	14 CORF	FISCAL YEAR ENDI	ING DATE: (L35)
8. ACCREDITATION ST	-	1 (L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 IMR		THE TENTO	ATO DATE. (ESS)
0 Unaccredited 2 AOA	1 TJC 3 Other		04 514	00 OF 1/3F	12 RHC	16 HOSPICE		
11. LTC PERIOD OF CE	RTIFICATION		10.THE FACILITY	IS CERTIFIED A	AS:	The second secon		Medical and a control of the control
From (a):			X A. In Complian	ce With		And/Or Approved Waivers Of	The Following Requirem	nents:
To (b):			Program Re Compliance			2. Technical Personnel		
12.Total Facility Beds		(L18)		ceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Di NF) 8. Patient Roo	
		(210)		осраното г ос		5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds		(L17)		pliance with Progr		10.1		
			Requireme	nts and/or Applie	d Waivers:	* Code: A *	(L12)	
14. LTC CERTIFIED BEI	D BREAKDOWN					15. FACILITY MEETS		
18 SNF	18/19 SNF	19 SNF	ICF	IMR		1861 (e) (1) or 1861 (j) (1):	YES (L15)	
(L37)	(L38)	(L39)	(L42)	(L43)				
. ,								
STATE SURVEY AG								
A licensure complain NC00123945, NC00						A deficiency was cited under 12453	10 NCAC 27G .1902	(b) Staffing.
17. SURVEYOR SIGNA	TURE_		Date:		T	18. STATE SURVEY AGENCY	APPROVAL	Date:
L			02	2/27/2017	(L19)			7.00
-	PARTII	- TO BE (COMPLETED R	V HCFA DE		OFFICE OR SINGLE S	TATE ACENCY	(L20)
10 DETERMINATION		- 10 BE (
19. DETERMINATION (PLIANCE WITH TS ACT:	CIVIL	 Statement of Final Ownership/Control 	ncial Solvency (HCFA-257 ol Interest Disclosure Stmt	
· .	s Eligible to Participa	ite				Both of the Above	:	,
2. Facility	is not Eligible	(L21)					***************************************	
22. ORIGINAL DATE	23. L	TC AGREEN	MENT 24.	LTC AGREEM	ENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION	1]	BEGINNING	DATE	ENDING DAT	E	VOLUNTARY 00	INVOLUI	NTARY
						01-Merger, Closure	05-Fail to	Meet Health/Safety
(L24)	((L41)		(L25)		02-Dissatisfaction W/ Reimburse		Meet Agreement
25. LTC EXTENSION D	DATE: 27. A	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER	
	Α	L Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provid	er Status Change
	(L27) E	D		(L44)			00-Active	
	E	3. Rescind Su	spension Date:					
				(L45)				
28. TERMINATION DAT	ΓE:	29.	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS		
			00000					
	(L2	28)			(L31)			
31. RO RECEIPT OF CM	C_1530		DETERMINATION	OF A DDD OTAT	DATE			
J. NO RECEIPT OF CM	W-1337	32	DETERMINATION	of AFTROVAL.	DATE			
	(L3	32)			(L33)	DETERMINATION APPI	ROVAL	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		MHL0601258	B. WING		-	02/0	3/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	3/27/18		
STRATE	GIC BEHAVIORAL CE	NTER-CHARLOT	TTE, NC 282		~ QM		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD TO THE APPROP	DBE	(X5) COMPLETE DATE
	physician board-elig psychiatry or a gene experience in the free adolescents with me (b) At all times, at le members shall be pror adolescents in eact (c) If the facility is he specifically assigned responsibilities clearly performed on an accuracion accuracion of the psychiatrist shall consultation to review or adolescent admitted	D2 STAFF Ill be under the direction of a lible or certified in child ral psychiatrist with atment of children and intal illness. ast two direct care staff resent with every six children ch residential unit. It is program, with exparate from those to this program, with exparate from those the medical unit or other all provide weekly a medications with each child ed to the facility.	V 315	A. Corrective Actions Pursuant to the findings, the by Strategic Behavioral Cent 1.) In order to ensure compl direct care staff to patients, S. Residential Counselor for th 2.) The Director of Nursing retraining with all residentia following content: a. The expectation that any pobservations are communicated and Staffing Coordinator. b. Expectations on supervisity. c. The requirement that at lebe present with every six chil	iance with the 2:6 iance with the 2:6 iance with the 2:6 iance with the 2:6 iance with the detailed an ade third shift. and Milieu Managl nursing staff on precautions or high ated to Residential on of hallways.	ratio of Iditional ger held the her level I Counselors	3/17/1
t s t s s s s s s s s s s s s s s s s s	(e) The PRTF shall proverage by a register overage by a register overage by a register overage by a register over over over over over over over ov	as evidenced by: ey review, medical record view, staffing schedule gative reports review and cility failed to have at least nembers present with every es for 7 of 10 sampled night		e. The requirements specific one to one status. 3.) Monthly Supervision t with each month to include limited to patient boundar interventions, Q15 documenew addition of 2:6 audit grid (see reference A and of observation. 4.) Schedule gaps whereby ratio cannot be met with the now being filled by the M Coordinator who are now work those gaps. B. Monitoring system that implemented including the monitoring to ensure of the monitoring to ensure of the monitoring conducted to enfacility staffing ratio is being specific and the monitoring ratio is being facility staffing ratio is being conducted to enfacility staffing ratio is seen conducted to enfacility s	npletion of staffin to 1:1, close observations is now being the topics including ries, restrictive mentation, to inclute tool and updated and updated and updated and updated are core and PRN ilieu Manager and arequired to come that been or will be person(s) responsion political assignment sheets assure that the required to conservations are that the required to compliance:	g sheets. rvation, and ing held g but not de the staffing and levels attent staff are l Staffing e in to one are	
		/8UPPLIER REP RES ENTATIVE'S SIGNA	TURE	TITLE	,) DATE
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3-16-17 If continuation sheet 1 of 10

resident of a "Resident Observation Record" dated 2016 third shift revealed documentation of

Open medical record review of Resident #10 revealed a

Review of a "Resident

revealed documentation of

Observation Record dated 2016 third shift

Review of Facility Shift Report for night shift on 2016 revealed Resident #9 1

Review of Facility Shift Report for night shift on 2016 revealed Resident #10

Review on 02/01/2017 at 1040 of a video recording of a seven minute time frame (not recorded with actual time) of 200 hall on 12/15/2016 night shift revealed one MHT located on the unit during the time of the recording (not

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3-16-17

Performance Improvement Meeting, the Medical

Responsible Person: Milieu Manager

of their respective meetings.

Executive Committee and Governing board at each

If continuation sheet 2 of 10

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING MHL0601258 02/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOT CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 315 Continued From page 2 V 315 consistent with the policy requirement of 2 staff to 6 residents). Review of the video revealed Resident #9 Review of staffing schedule dated 12/15/2016 revealed staffing for 2245 - 0715 included 2 Registered Nurses (RN's) and 10 staff. Review of the daily assignment sheet revealed there were two residents on one-on-one observation during the nights shift on 12/15/2016. Review of facility census on 12/15/2016 revealed there were a total of 36 residents on the 100, 200 & 300 units during the night shift. Review of daily assignment sheet for 12/15/2016 night shift revealed hall 200 (coed unit) had one (1) one-on-one resident on the night shift. Assignment sheet dated 12/15/2016 for the 2245 - 0715 shift for 300 hall revealed a current census of 12 residents with three MHT's assigned (not consistent with the policy requirement of 2 staff to 6 residents), for 200 hall revealed a current census of 12 residents with four MHT's (one MHT with one-on-one resident, leaving three MHT's to cover 11 residents) (not consistent with the policy

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requirement of 2 staff to 6 residents), and for 100 hall revealed a current census of 12 residents with three MHT's (not consistent with the policy

requirement of 2 staff to 6 residents).

Interview on 02/02/2017 at 1015 with Milieu Manager revealed "We do not include the nurses in the 2:6 ratio." Interview revealed the Milieu Manager assigns the Mental Health Techs, Resident Advisors and Resident Coordinators to the different units each day. The Milieu Manager assigns scheduled staff to the Psychiatric Residential Treatment units and the Acute Treatment units. Interview revealed the residents

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 02/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOT CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 315 Continued From page 3 V 315 ordered one-on-one and close observation along with the staff assigned for the duty should be documented on the daily assignment sheets. Interview confirmed the staffing ratio on 12/15/2016 was not consistent with the facility policy of two staff members for every six residents. 2. Review of medical record on 01/31/2017 revealed a Review of "Resident Observation Record" dated 2016 revealed documentation of patient 2016 through 2016 at "Resident Observation Record" revealed No issues to report." Review of Facility Shift Report for night shift on 2016 revealed No more issues to report." Review of staffing schedule on 12/18/2016 revealed staffing for 0645 - 1515 included 2 Registered Nurses (RN's) and 10 Mental Health Technicians (MHT's) and 2 Resident Coordinators (RC's), for 1445 - 2315 included 2 RN's and 11 MHT's and 2 RC's, for 2245 - 0715 included 1 RN and 11 MHT's. Review of facility census on 12/18/2016 revealed there were a total of 36 residents on the 100, 200 & 300 units during all three shifts. Review of daily assignment sheet for 12/18/2016 revealed the unit had 1 one-on-one resident on all three shifts.

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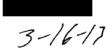
Further review of daily assignment sheets

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If continuation sheet 4 of 10



FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 02/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOT CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 315 Continued From page 4 V 315 revealed there was a MHT assigned to the one-on-one during each shift. Assignment sheet dated 12/18/2016 for the 2245 - 0715 shift for 100 hall revealed a current census of 12 residents with three MHT's assigned (not consistent with the policy requirement of 2 staff to 6 residents). for 200 hall revealed a current census of 12 residents with four MHT's (one MHT with one-on-one resident, leaving three MHT's to cover 11 residents) (not consistent with the policy requirement of 2 staff to 6 residents), and for 300 hall revealed a current census of 12 residents with three MHT's (not consistent with the policy requirement of 2 staff to 6 residents). Interview on 01/31/2017 at 1507 with Milieu Manager revealed "We do not include the nurses in the 2:6 ratio." Interview revealed the milieu manager assigns the Mental Health Techs, Resident Advisors and Resident Coordinators to the different units each day. The milieu manager assigns scheduled staff to the Psychiatric Residential Treatment units and the Acute Treatment units. Interview revealed the residents ordered one-on-one and close observation along with the staff assigned for the duty should be documented on the daily assignment sheets. Interview confirmed the staffing ratio on 12/18/2016 was not consistent with the facility policy of two staff members for every six residents. Review of "Resident Observation Record" 2017 revealed documentation of

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(evaluation) Resident

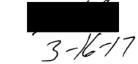
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"Resident Observation Record"

revealed documentation on evening shift "E



If continuation sheet 5 of 10

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 02/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOT CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 315 Continued From page 5 V 315 Review of Facility Shift Report for evening shift on 12/20/2016 revealed "Resident Review of staffing schedule on 12/20/2016 revealed staffing for 0645 - 1515 included 2 Registered Nurses (RN's) and 10 Mental Health Technicians (MHT's) and 2 Resident Coordinators (RC's), for 1445 - 2315 included 2 RN's and 13 MHT's and 2 RC's, for 2245 - 0715 included 1 RN and 10 MHT's. Review of facility census on 12/20/2016 revealed there were a total of 36 residents on the 100, 200 & 300 units during all three shifts. Review of daily assignment sheet for 12/20/2016 revealed the unit had 1 one-on-one resident on all three shifts. Further review of daily assignment sheets revealed there was a MHT assigned to the one-on-one during each shift. Assignment sheet dated 12/20/2016 for the 2245 - 0715 shift for 100 hall revealed a current census of 12 residents with three MHT's assigned (not consistent with the policy requirement of 2 staff to 6 residents), for 200 half revealed a current census of 12 residents with three MHT's (one MHT with one-on-one resident, leaving two MHT's to cover 11 residents) (not consistent with the policy requirement of 2 staff to 6 residents). and for 300 hall revealed a current census of 12 residents with four MHT's. Review of facility documents revealed 10

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investigative reports completed on 12/18/2016 and 4 investigative reports completed on

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If continuation sheet 6 of 10



Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 02/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOT CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION JD (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 315 Continued From page 6 V 315 12/20/2016 for multiple disturbances on the units related to sexual behaviors and altercations between residents. Interview on 01/31/2017 at 1507 with Milieu Manager revealed "We do not include the nurses in the 2:6 ratio." Interview revealed the milieu manager assigns the Mental Health Techs. Resident Advisors and Resident Coordinators to the different units each day. The milieu manager assigns scheduled staff to the Psychiatric Residential Treatment units and the Acute

ordered one-on-one and close observation along with the staff assigned for the duty should be documented on the daily assignment sheets. Interview confirmed the staffing ratio on 12/20/2017 was not consistent with the facility policy of two staff members for every six residents. 4. Review of staffing schedule dated 01/23/2017

Treatment units. Interview revealed the residents

revealed staffing for 2245 - 0715 included 2 Registered Nurses (RN's) and 10 staff. Review of facility census on 01/23/2017 revealed there were a total of 34 residents on the 100, 200 & 300 units during the night shift. Review revealed the staffing assigned was not consistent with the policy requirement of 2 staff to 6 residents.

Interview on 02/02/2017 at 1015 with Milieu Manager revealed "We do not include the nurses in the 2:6 ratio." Interview revealed the Milieu Manager assigns the Mental Health Techs. Resident Advisors and Resident Coordinators to the different units each day. The Milieu Manager assigns scheduled staff to the Psychiatric Residential Treatment units and the Acute Treatment units. Interview revealed the residents ordered one-on-one and close observation along

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If continuation sheet 7 of 10

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Division of Health Service Regulation

DIVIDION OF FICURE OCTATOR THE	guiation		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	MHL0601258	B. WING	02/03/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

V 315 Continued From page 7 with the staff assigned for the duty should be documented on the daily assignment sheets. Interview confirmed the staffing ratio on 01/23/2017 was not consistent with the facility policy of two staff members for every six residents. 5. Review of staffing schedule dated 01/29/2017 revealed staffing for 2245 - 0715 included 2 Registered Nurses (RN's) and 10 staff. Review of facility census on 01/29/2017 revealed there were a total of 34 residents on the 100, 200 & 300 units during the night shift. Review revealed the staffing assigned was not consistent with the policy requirement of 2 staff to 6 residents. Interview on 02/02/2017 at 1015 with Milleu Manager revealed "We do not include the nurses in the 2:6 ratio." Interview revealed the Millieu Manager assigns the Mental Health Techs, Resident Advisors and Resident Coordinators to the different units each day. The Milleu Manager assigns scheduled staff to the Psychiatric Residential Treatment units and the Acute Treatment units. Interview revealed the residents ordered one-on-one and close observation along with the staff assigned for the duty should be documented on the daily assignment sheets. Interview confirmed the staffing ratio on 01/29/2017 was not consistent with the facility policy of two staff members for every six residents. 6. Review of staffing schedule dated 01/30/2017 revealed staffing for 2245 - 0715 included 2 Registered Nurses (RN's) and 8 staff. Review of facility census on 01/30/2017 revealed staffing for 2245 - 0715 included 2 Registered Nurses (RN's) and 8 staff. Review of facility census on 01/30/2017 revealed staffing for 2245 - 0715 included 2 Registered Nurses (RN's) and 8 staff. Review of facility census on 01/30/2017 revealed staffing for 2245 - 0715 included 2 Registered Nurses (RN's) and 8 staff. Review of facility the night shift. Review of facility the night shift. Review of facility census on 01/30/2017 revealed staffing for 2455 - 0715 included 2	STRATE	GIC BEHAVIORAL CENTER-CHARLOT	ARON ROAL		
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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601258 02/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOT CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 315 Continued From page 8 V 315 one-on-one resident on night shift. Review revealed the staffing assigned was not consistent with the policy requirement of 2 staff to 6 residents Interview on 02/02/2017 at 1015 with Milieu Manager revealed "We do not include the nurses in the 2:6 ratio." Interview revealed the Milieu Manager assigns the Mental Health Techs. Resident Advisors and Resident Coordinators to the different units each day. The Milieu Manager assigns scheduled staff to the Psychiatric Residential Treatment units and the Acute Treatment units. Interview revealed the residents ordered one-on-one and close observation along with the staff assigned for the duty should be documented on the daily assignment sheets. Interview confirmed the staffing ratio on 01/30/2017 was not consistent with the facility policy of two staff members for every six residents. 7. Review of staffing schedule dated 01/31/2017 revealed staffing for 2245 - 0715 included 2 Registered Nurses (RN's) and 11 staff. Review of facility census on 01/31/2017 revealed there were a total of 34 residents on the 100, 200 & 300 units during the night shift. Review of daily assignment sheet for 01/31/2017 revealed 1 one-on-one resident on night shift. Review

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residents.

revealed the staffing assigned was not consistent

with the policy requirement of 2 staff to 6

Interview on 02/02/2017 at 1015 with Milieu Manager revealed "We do not include the nurses in the 2:6 ratio." Interview revealed the Milieu Manager assigns the Mental Health Techs, Resident Advisors and Resident Coordinators to the different units each day. The Milieu Manager

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If continuation sheet 9 of 10

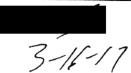


PRINTED: 02/26/2017 Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL0601258 02/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOT CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) V 315 Continued From page 9 V 315 assigns scheduled staff to the Psychiatric Residential Treatment units and the Acute Treatment units. Interview revealed the residents ordered one-on-one and close observation along with the staff assigned for the duty should be documented on the daily assignment sheets. Interview confirmed the staffing ratio on 01/31/2017 was not consistent with the facility policy of two staff members for every six residents. NC00123945, NC00123747, NC00123722, NC00123717, NC00124277, NC00124471, NC0012453

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If continuation sheet 10 of 10

Strategic Behavioral Health, Charlotte COMPLIANCE WITH STAFFING GRID ASSIGNMENTS FOR NURSING UNITS

DATE		DAYS		EVENINGS		NIGHTS	
	Type of Staff	Staff Required	Staff Actual	Staff Required	Staff Actual	Staff Required	Staff Actual
		tient halls joined by a nui F Units: 100,200,300	rsing station with exception of	100, 300, and 400 halls whe	reby one hall is Acute and	i one PRTF.	
100	RN						
	LVN						
	мнт						
200	RN						
	LVN						
	мнт				·		
700	RN						
	LVN						
	мнт						
800	RN						
	LVN						
	мнт						
300	RN						
	LVN						
	МНТ						
400	RN						
	LVN						
	МНТ						
500	RN						
	LVN					,	
	МНТ						
600	RN						
	LVN						
	мнт						
monte					1		1

Comments:					
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***************************************	······································	······			

Strategic Behavioral Health, Charlotte COMPLIANCE WITH 2:6 RATIO ON PRTF UNITS

Instructions: Indicate the # of staff and patients for each observation conducted. For example 2/6: 4/12

		stan and patients to	Cacii observatioti	Conducted. For ex	ample 2/0, 4/12			
Unit/Area	Shift/time	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
2017	DATE:							
PRTF UNITS/PA	TIENT AREA							
100	DAYS							
	EVES							
	NOCS							
		And the second s						
200	DAYS							
	EVES							
	NOCS							
	<i>'</i>				I.			
300	DAYS							
	EVES							
	NOCS							
400	DAYS							
	EVES							
	NOCS			**************************************				
500	DAYS							
	EVES							
	NOCS							
CAFETERIA	DAYS							
CAFETERIA	PM							
on Elera	, 							
DEC DOC'								
REC ROOM								
1		Ţ						
COURTYARD								
CLASSROOM	-							
ame of Aud	itor/Title/Da	te/Time					. ,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: W9JRI1

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	TAKI 1-	TO BE COMPT	LEIED DY II	IE SIA	TE SURVEY AGENCY	Facility ID: 9429360113		
MEDICARE/MEDICAID PROVII (L1)	DER NO.	3. NAME AND AL (L3) STRATEGIO			TER-CHARLOTTE	4. TYPE OF ACTION: <u>6 (</u> L8)		
2.STATE VENDOR OR MEDICAID	NO.	(L4) 1715 SHAR	ON ROAD WES	ST		1. Initial 2. Recertification		
(1.2)		(L5) CHARLOT	TE, NC		(L6) 28210	3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEGO	RY	<u>06</u> (L7)	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
(L9)		01 Hospital	05 HHA	09 ESI	RD 13 PTIP	o. Full Survey After Complaint		
	(L34)	02 SNF/NF/Dual	06 LAB	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 IM7		()		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RH	C 16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY		S:		-		
From (a):		X A. In Complia Program R	ince With equirements		And/Or Approved Waivers Of	The Following Requirements:		
To (b):			e Based On:		2. Technical Personnel	_ 6. Scope of Services Limit		
12. Total Facility Beds	(L18)	Y 1 A	. Acceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Director F) 8. Patient Room Size		
	(E10)	A	eceptable FOC		5. Life Safety Code	9. Beds/Room		
13. Total Certified Beds	(L17)		npliance with Progra		***			
		Requireme	ents and/or Applied	i Waivers	* Code: A1*	(L12)		
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IMR		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
STATE SURVEY AGENCY REM								
A complaint investigation was	conducted at the fac	cility September 19	-21, 2017. A defi	iciency v	vas cited in State Licensure for N	Mental Health/Substance Abuse for HCPR-24		
Hour Reporting 130 .0102 . Ap	or correction w		ine lacility. NCO	7131494				
17. SORVEYTID SILINATTIDE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
		1	0/09/2017					
				(L19)		(L20)		
PA	RT II - TO BE (COMPLETED E	BY HCFA REC	GIONA	L OFFICE OR SINGLE ST	TATE AGENCY		
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WITH (HTS ACT:	CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
1. Facility is Eligible to	Participate	RIGH	IISACI:		Ownership/Control Both of the Above	ol Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible						White the con-		
	(L21)		-					
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	LTC AGREEME	ENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE		VOLUNTARY 00	INVOLUNTARY		
					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ment 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)			(L44)			00-Active		
. (==-/	B. Rescind Su	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		00000						
	(L28)		,	(L31)				
31 PO PECEIPT OF CLASS 1622		DETERMINE	OF ADDROVES T					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	DALE				
	(L32)			(L33)	DETERMINATION APPR	OVAL		

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING MHL0601258 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOT CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRFFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 318 13O .0102 HCPR - 24 Hour Reporting Please note that the response is being prepared in the V 318 following format: a) the processes that led to the deficiency cited; b) The procedure for implementing 10A NCAC 13O .0102 **INVESTIGATING AND** the acceptable plan of correction for the specific REPORTING HEALTH CARE PERSONNEL deficiency cited; c)The monitoring procedure to ensure The reporting by health care facilities to the that the plan of correction is effective and that specific Department of all allegations against health care deficiency cited remains corrected and/ or in personnel as defined in G.S. 131E-256 (a)(1), compliance with the regulatory requirements. d) The including injuries of unknown source, shall be title of the person responsible for implementing the done within 24 hours of the health care facility acceptable plan of correction; e) The date by which all becoming aware of the allegation. The results of corrective action will be completed and the monitoring the health care facility's investigation shall be system will be in place submitted to the Department in accordance with a)Corrective Actions The report of the allegation of a staff e) 10/13/17 G.S. 131E-256(g). member striking a patient was still under review and the Director of Quality, Compliance, and Risk Management (DQCR) was still collecting information at the 24 hour required reporting time and, because her report was incomplete, had not yet reported same. b) Procedure for Implementation. (1)As a result of this finding, the DQCR has been re-educated by the SBH Chief Compliance Officer on requirements related to allegations This Rule is not met as evidenced by: including allegations of staff-to-resident abuse and the Based on resident family interview, policies and associated reporting requirements related to such allegations procedures, internal investigation review, medical including the report is to be submitted within 24 hours of record review, and staff interview, the facility becoming aware of the allegation.(2)Effective immediately, to failed to report an allegation of abuse to the ensure compliance with the requirement for DQCR to report Health Care Personnel Registry (HCPR) within 24 an allegation of staff-to-resident abuse within 24 hours of hours of becoming aware of the allegation for 1 of becoming aware, 100% of patient verbal report or external 2 sampled patients that alleged staff abuse complaints received will be presented by the DQCR to the (Patient #1). CEO (and in his absence the Regional VP) on a M through F basis to ensure that timeliness of the reports to DQCR is Findings included: occurring. This process will be conducted on an ongoing basis. Failure to follow procedure and timeliness of A telephone interview with resident #1's submission of reports to the HCPR will be addressed through was done on 09/21/2017 at 1110 per the progressive disciplinary process. request to facility. The interview revealed that the c) Monitoring Procedure. The results of all investigations as well as mother was upset that had learned on the DQCR's compliance with timeliness of reporting events to the 2017 that resident #1 had HCPR within 24 hours of the facility becoming aware including being slapped by a staff member reported to injuries of unknown source, will be reported by the DQCR to the after The Quality/PI Council, the Medical Executive Committee, and the reported was called by the facility statt on Governing Board at each of their respective meetings on a monthly 2017) and told about basis. If at 100% compliance for four consecutive months, the but was not told about the alleged slap. frequency for reporting to the Committees will reduce to quarterly. The interview revealed that the d) Responsible Person. Director of Quality, Compliance, Risk Management (DQCR), Division of Health Service Regulation

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LABORATORY DIRECTO

S SIGNATURE

TITLE

(X6) DATE

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0601258	B. WING			C 21/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
STRATE	GIC BEHAVIORAL CEI	NTER-CHARLOT 1715 SHA	ARON ROAD	WEST		
044) 15	CUMMADY CTA		TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 318	Continued From page	ge 1	V 318			
	wanted to have a th completed.	orough investigation				
	REGULATORY OR LSC IDENTIFYING INFORMATION) B Continued From page 1 wanted to have a thorough investigation					
Ni dalaa afili	the record revealed					

Division of Health Service Regulation

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PRINTED: 10/05/2017 **FORMAPPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED C B. WING _ MHL0601258 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOT CHARLOTTE, NC 28210 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 318 Continued From page 2 V 318 The documentation revealed vo documentation was found in the record that the resident alleged was hit by staff. Interview on 09/21/2017 at 1205 with the facility's DQCR (Quality/Risk Management) revealed: NC00131494; NC00131571; NC00131034; NC00131451; NC00130219; NC00131573

Division of Health Service Regulation

RVICES DEPARTMENT OF HEALTH AND HUMAI CENTER: R MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 4IND11 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 9429360113 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 6 (L8) (L3) STRATEGIC BEHAVIORAL CENTER-CHARLOTTE (L1) 1. Initial 2. Recertification (L4) 1715 SHARON ROAD WEST 2.STATE VENDOR OR MEDICAID NO. 3. Termination 4. CHOW (L6) 28210 (L2)(L5) CHARLOTTE, NC 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 06 7. PROVIDER/SUPPLIER CATEGORY (L7) 8. Full Survey After Complaint (L9) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 10 NF 6. DATE OF SURVEY (L34)02 SNF/NF/Dual 06 PRTF 14 CORE FISCAL YEAR ENDING DATE: (1.35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct (L10) 07 X-Ray 11 ICE/IID 15 ASC 0 Unaccredited I TJC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE 12/31 2 AOA 3 Other 10.THE FACILITY IS CERTIFIED AS: 11. .LTC PERIOD OF CERTIFICATION From (a): X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: To (b): Program Requirements ___ 2. Technical Personnel Scope of Services Limit Compliance Based On: ___ 3. 24 Hour RN __ 7. Medical Director ___ 4. 7-Day RN (Rural SNF) Acceptable POC 8. Patient Room Size 12. Total Facility Beds (L18) ___ 5. Life Safety Code __ 9. Beds/Room (L17) 13. Total Certified Beds B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12) A* * Code: 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): YES (L15) (L37)(L38)(L39)(L42)(L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks 17. SURVEYOR SIGNATURE Date: STATE SURVEY AGENCY APPROVAL Date: 07/31/2017 (L19) (L20)PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above : Facility is not Eligible (1.21)22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30)OF PARTICIPATION BEGINNING DATE VOLUNTARY 00 ENDING DATE INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41) (L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS OTHER 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change

(L44)

(L45)

30. REMARKS

DETERMINATION APPROVAL

(L31)

(L33)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

00000

(L27)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539

B. Rescind Suspension Date:

(1.28)

(L32)

00-Active

DEPARTMENT OF HEALTH AND HUMA: ERVICES

CENTER

VR MEDICARE & MEDICAID SERVICES

MEDICA: //MEDICAID CERTIFICATION AND TRANSMATAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 4IND11

Facility ID: 9429360113

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

A complaint investigation was conducted May 1, 2017 through May 4, 2017. Federal standard level deficiencies were cited in 483.374 Facility Reporting and at NCAC 27G.1902 Staff; NCAC 130.0102 Investigating and Reporting Health Care Personnel; and 122C-62 Additional Rights in a 24-Hour Facility. A Plan of Carrection was requested approved 07/31/2017.

- Reviewed IMPPROVED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES **REC'D JUL 18 2017**

FORM APPROVED

OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		9429360113	B. WING			05/	05/2017
NAME OF DE	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/1	03/2017
NAME OF T	NO VIDER OR GOT FEIER			1	715 SHARON ROAD WEST		[
STRATEG	IC BEHAVIORAL CENT	ER-CHARLOTTE			CHARLOTTE, NC 28210		
						· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 207	483.374(b) FACILIT	Y REPORTING	N	207	preared in the following format.		(c) 06/01/17
	Reporting of serious	occurrences.			(a) A description of the corrective action(s)	į
		ort each serious occurrence			and the systems that have been or will be		1
	to both the State Me	dicaid agency and, unless	•		implemented to correct the deficiencies.		
	prohibited by State la	aw, the State designated			(b) A description of the monitoring system		
	Protection and Advo				that has been or will be implemented.		
	Serious occurrences	that must be reported			(c) Implementation date		
	include;				Pursuant to this finding, the following action	ns have	
	 a resident's dea 	The second secon			been taken:		
		to a resident as defined in			483.374(b) Facility Reporting		1
	section §483.352 of				(a) Corrective actions		
	- a resident's suic	t any serious occurrence			1 ' '	I. (DOOD)	
		to both the State Medicaid			(1)The Director of Compliance/Quality/Ris	` '	
		e designated Protection and			the Director of Nursing and the CEO have		
		no later than close of			been educated through face to face		
		isiness day after a serious			discussion and telephone conference		
	occurrence. The rep	ort must include			with the Corporate Compliance Officer on	the	
	- the name of the	e resident involved in the			associated reporting requirement that 100	% of	
	serious occurrence,				serious occurrences involving a resident a	re to	
		the occurrence and,			be reported to the State designated Prote	ction and	
		t address, and telephone			Advocacy system by the Director of Comp	liance/	
	number of the facility	,			Quality/Risk in accordance with the requir frames and content.	ed time	
	This ELEMENT is n	ot met as evidenced by:			(2) A system has been established where	by	
		rolina Administrative Code			all patient occurrences will be discussed		
	(NCAC) and Genera	l Statutes (GS) reviews,			on a Monday through Friday basis (with e	events	
	facility policy review	, medical record review,			occurring on Friday, Saturday, and Sunda		
	facility investigative	findings, and staff interviews,			Incorporated into Monday's report) at the	•	
		d to report an attempted				•	
		dent) to the State Medicaid			Patient Safety Committee meeting. All or	currences	
		ection and Advocacy system			deemed as serious occurrences shall be		
	for 1 of 1 sampled re	esidents (Resident #1).			reported to the State Medicaid agency an		
	The findings include				the state designated Protection and Advo	cacy syste	m
	The findings include	•			no later than close of business the next		
	Review on 05/04/20	17 of North Carolina			business day after the serious occurrence). .	
	1	revealed, "10A NCAC					
			<u></u>		TITLE		(X6) DATE
_ABORATOR		JATU!	\L		(60)	~	219-

Any deficiency statement ending with an asteristant) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID:

Facility ID: 9429360113

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		9429360113	B. WING			1	C
	ROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 715 SHARON ROAD WEST CHARLOTTE, NC 28210	05/	05/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 207	PROVIDERS (a) Cate shall report all level II during the provision of the consumer is on the premiseswithin 72 the incident." Review on 05/04/201 Division of Mental He Disabilities, and Subs "Incident Response a revealed, "C. Incide Consumer Behavior: behavior that results threat to the health of Review on 05/01/201 Patient", Policy Number reviewed/revised 12/2 suiciderequirecl Heightened Observations assessed to be at mosuicidality may be pla (1:1) observation state Observation policy. Review on 05/01/201 Patient Observation; reviewed/revised 12/2 One Observation: The assignment of one state client and is will at all timesProcedurwill be evaluated dimensioned.	REPORTING OR CATEGORY A AND B egory A and B providers incidentsthat occur of billable services or while he providers hours of becoming aware of 7 of the North Carolina halth, Developmental stances Abuse Services 2011 had Reporting Manual" hent Categories7. Report anydestructive himor a potentially serious has afety of self or others." 7 of the facility's "Care of her 1300.07 her 130		207	b. Monitoring system (1)To ensure compliance with this requ 100% of occurrences reported through incident reporting system and through incident report will be audited by the Safety Cordaily to ensure that all reportable occurrences have been identified as such and the reports initiated, as required. (2) Compliance with this process and the associated findings will be reported by DCQR on a Monday through Friday be at the Hospital's Morning meeting for four consecutive months. A compliance rate of 100% is required. (3) The results of this report will be forwarded by the DCQR to the Quality/Council, the Medical Executive Commit the Governing Board at each of its responsetings through year-end, 2017.	the shift nmittee ne the sis	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
						0	
		9429360113	B. WING			05/0	05/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1715 SHARON ROAD WEST		
STRATEG	IC BEHAVIORAL CENTE	R-CHARLOTTE		١,	CHARLOTTE, NC 28210		
			T	1	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		- 1	(X5) COMPLETION DATE
N 207	N 207 Continued From page 2		N	207	7		
	Reporting Policy", Po						
		2016, revealed, "Policy:					
		also provide open and timely					
		as required by CARF					
		reditation of Rehabilitation					-
		e, and federal entities.					
	Incidents - Any unu	•					·
		ts in injury or potential injury					· ·
		Director of Risk Management					
		l be responsible for reporting					
		lents to external entities as					
	defined by regulation	or standard					
	Resident #1 revealed	Review of daily nursing				-	
				,			
	Review of physician	orders by MD on					
		evealed					
	2017 41	cvdaldd					
		Review of an					
	"EVALUATION OF R	ISK" performed by LP					
		evealed					
		Review of					
	a physician's progres						
		revealed,					
		Further review failed to					
	reveal additional info						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED .		
		9429360113	B. WING					05/2017	
	ROVIDER OR SUPPLIER	R-CHARLOTTE		STREET ADDRESS, CITY, STATE, ZIP CODE 1716 SHARON ROAD WEST CHARLOTTE, NC 28210					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)				(X5) COMPLETION DATE	
N 207	Continued From page	e 3 7 of a document provided by	N	207					
	the director of quality, (DQCR) on 20° progress note by RN Review revealed, "(R	compliance and risk 7 at revealed a					ì		
	Review revealed,	Review revealed							
		another entry by RN evealed,			,				
	revealed revealed nterview revealed	Interview							
	Interview revealed Interview on	/2017 at with the							

	OF OFFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI F	CONSTRUCTION	(X3) DATE S	SURVEY	
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			· . ~	COMPL		
				-		c	;	
		9429360113	B. WNG			05/0	05/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
etdatec	IC BEHAVIORAL CENTE	P-CHARLOTTE			15 SHARON ROAD WEST			
STRAILG	IC BEHAVIORAL CENTE	N-CHARLOTTE		C	HARLOTTE, NC 28210			
(X4) ID PREFIX TAG	(EACH DEFICIENC	DEFICIENCY MUST BE PRECEDED BY FULL		EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED T		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 207	Continued From page	e 4 017 at 1605 with RN	N	207				
	MHT presented to	revealed the nursing station and ith him to evaluate Resident revealed	-					
	Inte	Interview revealed erview revealed					•	
		Interview revealed the						
		017 at 1715 with MHT igned to the hall Resident #1 revealed						
	Interview re	vealed the resident						
	An interview with the (CEO) and DQCR or revealed,	chief executive officer n 2017 at 0845						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		9429360113	B. WING		C 05/05/2017	
	ROVIDER OR SUPPLIER IC BEHAVIORAL CENTE	R-CHARLOTTE		STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST CHARLOTTE, NC 28210	00/00/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MARY STATEMENT OF DEFICIENCIES ID FICIENCY MUST BE PRECEDED BY FULL PREFIX DRY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DN
N 207	Continued From page		N 20	7		
	Department Staff #1 v Department of Health Division of Mental Health Disabilities, and Subs (NCDHHS: MHDDSA: Services revealed the the facility regarding in Interview revealed the "all level II incidents" a 27G.0604. Interview r failed to report Medicaid agency.	on 05/24/2017 at 1045 with with the North Carolina and Human Services alth, Developmental				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART 1 - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: SHHU11

	PART I -	TO BE COMPL	ETED BY TI	HE STAT	E STATE SURVEY AGENCY Facility ID: 942936			
MEDICARE/MEDICAID PROVIL (L1) 2.STATE VENDOR OR MEDICAID (L2)		3. NAME AND AD (L3) STRATEGIC (L4) 1715 SHARO (L5) CHARLOTT	E BEHAVIORA ON ROAD WES	AL CENT	ER-CHARLOTTE (1.6) 28210	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	DN: 6 (L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER:SUI	PPLIER CATEGO	ORY 09 ESRI	06 (1.7) D 13 PT1P	7. On-Site Visit 8. Full Survey Afte	9. Other	
6. DATE OF SURVEY 09/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(I.10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 LAB 07 X-Ray 08 OPT/SP	10 NF 11 IMR 12 RHC		FISCAL YEAR ENDI	ING DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	(L18) (L17)	B Not in Com	nce With equirements	am	And Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code. A*	6. Scope of S 7. Medical D	Services Limit Director om Size	
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF (L37) (L38)		ICF (1.42)	IMR (1.43)	1	5. FACILITY MEETS 1861 (c) (1) or 1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REM A complaint investigation was of the survey		Date :			were found during the investi		Date:	
PA	RT II - TO BE	COMPLETED B	Y HCFA REC		OFFICE OR SINGLE S	TATE AGENCY	(L20)	
DETERMINATION OF ELIGIBI 1. Facility is Eligible to 2. Facility is not Eligible	Participate		PLIANCE WITH TS ACT	CIVII.				
22. ORIGINAL DATE OF PARTICIPATION (L24)	23. LTC AGREFI BEGINNING (L41)		LTC AGREEMI FNDING DATI (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger. Closure 02-Dissatisfaction W: Reimburs	05-Fail to	(L30) NTARY Meet Health/Safety Meet Agreement	
25. LTC EXTENSION DATE: (L27)		VE SANCTIONS In of Admissions: Uspension Date.	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	er Status Change	
28. TERMINATION DATE:	(L28)	. INTERMEDIARY C	CARRIFR NO	(1.31)	30 REMARKS			
31. RO RECEIPT OF CMS-1539	(1.32)	DETERMINATION	OF APPROVAL.I	DATE (L33)	DETERMINATION APP	ROVAL		
				- 1				

PRINTED: 10/05/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		9429360113	B. WING			C 09/21/2017	
	PROVIDER OR SUPPLIER	NTER-CHARLOTTE		171	REET ADDRESS, CITY, STATE, ZIP CODE 15 SHARON ROAD WEST HARLOTTE, NC 28210	1 001	172017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
N 000	Initial Comments		N	000		,	
	No deficiencies were found during the complaint investigation conducted 09/19/2017 through 09/21/2017.						
	NC00130219.						
:							
				A STATE OF THE PROPERTY OF THE			
							·
				Walter the Control of			
							,
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART L- TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	RN	ΥN	11	
Faci	lity	ID:	1504	60

	PARI I -	TO BE COMPI	ELEDBITH	IE SIA	TE SURVET AGENCE			
MEDICARE/MEDICAID PROVIDER (L1) 344031	R NO.	3. NAME AND ADDRESS OF FACILITY (L3) STRATEGIC BEHAVIORAL CENTE			ER-CHARLOTTE	4. TYPE OF ACTION:	2. Recertification	
2 STATE VENDOR OR MEDICAID NO	Э.	(1.4) 1715 SHAR	ON ROAD WES	Т	10210	3. Termination	4. CHOW	
(L2)		(L5) CHARLOT	TE, NC		(L6) 28210	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU	JPPLIER CATEGO 05 HHA	RY 09 ESR	01 (1.7)	8. Full Survey After (Complaint	
6. DATE OF SURVEY 09/21/	2017 (L34)	02 SNE/NF/Dual	06 LAB	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 IME	15 ASC	FISCAL YEAR ENDING	DATE: (L35)	
0 NOT ACCREDITED 1 JC 2 AOA/HFAP 3 DNV G 4 TJC & AOA 5 DNV G 6 DNV & TJC 7 DNV & 8 DNV, TJC, & AOA 9 CHQ	L	04 SNF	08 OPT/SP	12 RHe	C 16 HOSPICE	12/31		
11. LTC PERIOD OF CERTIFICATION	l		Y IS CERTIFIED A	S:		The Following Peguiremen	te:	
From (a):		X A. In Complia	ance With Requirements		And/Or Approved Waivers Of			
To (b):			ce Based On:		2. Technical Personne 3. 24 Hour RN	6. Scope of Ser 7. Medical Dire		
		1	and the BOO		4. 7-Day RN (Rural S			
12.Total Facility Beds	(L18)	1. /	Acceptable POC		5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	(L17)		mpliance with Progr nents and/or Applie		A Code: A #	(1.12)		
14. LTC CERTIFIED BED BREAKDO	wn				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	. IMR		1861 (e) (1) or 1861 (j) (1):	(L15)		
10 311								
(L37) (L38)	(L39)	(L42)	(1.43)					
16. STATE SURVEY AGENCY REM.	ARKS (IF APPLICA	ABLE SHOW LTC C	ANCELLATION D	ATE):				
A complaint investigation was co	onducted at the h	ospital September	19-21, 2017. No o	deficienc	ies were found during the inve-	stigation. NC00131317.		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC		Date:	
Tr. Solite Fold Syding of the								
			10/09/2017	(1.19)			(L20	
PA	RT II - TO BE	COMPLETED	BY HCFA RE		L OFFICE OR SINGLE	STATE AGENCY		
19. DETERMINATION OF ELIGIBIL		20. CO	MPLIANCE WITH					
1. Facility is Eligible to I	Participate	·	JIII J ACT.		3. Both of the Abo			
2. Facility is not Eligible	:							
	(L21)				T			
22. ORIGINAL DATE	23. LTC AGREE	EMENT	24. LTC AGREEM	MENT	26. TERMINATION ACTIO		L30)	
OF PARTICIPATION	BEGINNIN	IG DATE	ENDING DAT	ΓE	VOLUNTARY	00 INVOLUN		
					01-Merger, Closure		Meet Health/Safety	
(L24)	(L41)		(1.25)		02-Dissatisfaction W/ Reimbu		Meet Agreement	
25. LTC EXTENSION DATE:		TIVE SANCTIONS			03-Risk of Involuntary Termina	OTHER		
a. bie britainigh britai		on of Admissions:			04-Other Reason for Withdraws		er Status Change	
			(1.44)			00-Active		
(L27)	B. Rescind	Suspension Date						
			(1,45)			4		
28. TERMINATION DATE:		29. INTERMEDIAR	Y'CARRIER NO.		30. REMARKS			
		00000						
	(1.28)			(1.31)				
31. RO RECEIPT OF CMS-1539		32. DETERMINATIO	ON OF APPROVAL	DATI:				
	(L32)			(1.33)	DETERMINATION AP	PROVAL		
	(

PRINTED: 10/05/2017 FORM APPROVED OMB NO 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		344031	B. WING				C 21/2017
	PROVIDER OR SUPPLIER GIC BEHAVIORAL CE	NTER-CHARLOTTE		171	REET ADDRESS, CITY, STATE, ZIP CODE IS SHARON ROAD WEST IARLOTTE, NC 28210	1 007	21/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
A 000	INITIAL COMMENT	rs	AO	000			
	No deficiencies we investigation condu 09/19/2017 through	ere found during the complaint cted at the hospital on 09/21/2017.					
	NC00131317.						
							-
The state of the s							
				The second secon			
ABORATORY	DIRECTOR'S OR PROVIDE	er/Supplier representative's sign	IATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	PART				TE SURVEY AGENCY		ID: RGLM11 Facility ID: 9429360113
MEDICARE/MEDICAID (L1) 2.STATE VENDOR OR MEI (L2)		3. NAME AND AI (L3) STRATEGI (L4) 1715 SHAR (L5) CHARLOT	C BEHAVIORA ON ROAD WE	AL CENT	ER-CHARLOTTE	4. TYPE OF ACTI 1. Initial 3. Termination	ON: <u>7 (L8)</u> 2. Recertification 4. CHOW
5. EFFECTIVE DATE CHAI		7. PROVIDER/SU	JPPLIER CATEGO	09 ESRD	(L6) 28210 06 (L7) 13 PTIP 22 CLIA	5. Validation 7. On-Site Visit 8. Full Survey Aft	6. Complaint 9. Other er Complaint
6. DATE OF SURVEY 8. ACCREDITATION STATE 0 Unaccredited 2 AOA	(L34) US: <u>1</u> (L10) 1 TJC 3 Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	ING DATE: (L35)
11. LTC PERIOD OF CERTIFIED From (a): To (b):	FICATION	Complianc	ance With equirements e Based On:	AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN	6. Scope of S 7. Medical D	Services Limit
12.Total Facility Beds 13.Total Certified Beds	(L18) (L17)	B. Not in Con	cceptable POC npliance with Prog and/or Applied W		4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A*	F) 8. Patient Ro 9. Beds/Room (L12)	
14. LTC CERTIFIED BED BI	REAKDOWN			I	15. FACILITY MEETS		
18 SNF 18/	19 SNF 19 SN	F ICF	IID		1861 (e) (1) or 1861 (j) (1):	(ES (L15)	
(L37)	L38) (L39)	(L42)	(L43)				
Psychiatric Rehabilitato 17. SURVEYOR SIGNATUR	in Treatment Facilitys	(PRTF). A deficiency Date:	in Judicial Revi	ew of Volu	016 to investigate the facility's untary Admission was cited as a 18. STATE SURVEY AGENCY	result of the investig	Rules Governing station NC00121541 Date: (L20
	PART II - TO B	E COMPLETED I	BY HCFA REC	GIONAL	OFFICE OR SINGLE ST	TATE AGENCY	
19. DETERMINATION OF E 1. Facility is Eli 2. Facility is no	gible to Participate	RIGH	PLIANCE WITH ITS ACT:	CIVIL	21. 1. Statement of Finan2. Ownership/Control3. Both of the Above	Interest Disclosure Stm	72) t (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGRE	EEMENT 24	LTC AGREEM	ENT	26. TERMINATION ACTION:	4.40	(L30)
OF PARTICIPATION	BEGINNI	NG DATE	ENDING DATE	E	VOLUNTARY 00 01-Merger, Closure	. <u>INVOLU</u>	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburser		Meet Agreement
25. LTC EXTENSION DATE	A. Suspens	TIVE SANCTIONS ion of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	ler Status Change
`	/ B. Rescing	Suspension Date:	(L45)				
28. TERMINATION DATE:		29. INTERMEDIARY/	CARRIER NO.		30. REMARKS	William Committee Committe	
		00000					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-15	39	32 DETERMINATION	OF A PDP OVAL	DATE			

(L33)

DETERMINATION APPROVAL

(L32)

Division of Health Service Restatement of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MUITI	PLE CONSTRUCTION	Town BATE	011011511
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	1	G:	(X3) DATE COMP	LETED
	MHL0601258	B. WING		10/2	7/2016
IAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	, STATE, ZIP CODE	12/16	
STRATEGIC BEHAVIORAL CE	NIFR-CHARLOL	ARON ROAD	,	I on	
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 365 G.S. 122C-224 Judi Admission § 122C-224. JUDIO		V 365			
facility where the min same restrictions on present in the State to similar restrictions the district court in the 24-hour facility is loc day that the minor is continuance of not magnated. (b) Before the according to the minor and person with written in procedures for court informing them about They shall also be in request for discharge minor for 72 hours do may apply for a petitic commitment. (c) Within 24 hours do facility shall notify the where the facility is loc been admitted and the in the admission must notice is given to schedule in the legally responsing responsible professions.	or is admitted to a 24-hour nor will be subjected to the his freedom of movement facilities for the mentally ill, or s, a hearing shall be held by he county in which the sated within 15 days of the admitted to the facility. A hore than five days may be dmission, the facility shall dhis legally responsible information describing the review of the admission and at the discharge procedures, formed that, after a written e, the facility may hold the uring which time the facility on for involuntary urs after admission, the e clerk of court in the county potated that the minor has not a hearing for concurrence is the scheduled. At the time edule a hearing, the facility of the names and addresses sible person and the onal. (1975, c. 839; 1977, c. 1; 1983, c. 889, ss. 1, 2;		A. Corrective Actions Pursuant to the findings, the followir actions were taken by Strategic Beh Center, Charlotte (SBC-C): 1) SBC-C has hired and has fully trafull time employee to serve as the "CRecord Custodian". The Court Record Custodian handles all the paperwork both the PRTF and Acute units and duties/ daily processes which estable by SBC-C and SBC-C attorney. 2) This new Gourt Record Custodian received competency training specifications. As part of his training, the Court Records Custodian has been specifically instructed to, in order to ensure that hearing for concurrence in the admission notify the clerk of court in the county the facility is located that a minor has admitted to the Acute or PRTF Units that a hearing for concurrence in the admission is scheduled;	avioral	<u>C.</u> 12/2/2016
This Rule is not met Based on review of th	as evidenced by: ne North Carolina General		RESPONSE CONTINUED ON THE	NEXT PAGE	
ion of Health Service Regulation	ER REPRESENTATIVE'S SIGNA		TITLE		

RGLM11

Division of Health Service R	egulation			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	B. WING		10/27/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
STRATEGIC BEHAVIORAL CE	-NIER-CHARTOI	RON ROAD		
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE COMPLETE
FOR HEARING" do facility staff failed to 24 hours of a minor Residential Treatment N.C.G.S. for 13 of 411, #10, #12, #18, and #14). Findings include: Review of N.C.G.S. 122C-224. Judicial admission." reveale after admission, the county of that the minor has been bearing for concurred.), medical records, "REQUEST ocuments, and staff interviews, o notify the clerk of court within r's admission to a Psychiatric ent Facility (PRTF) pursuant to 13 sampled residents (#13, #2, #15, #16, #17, #7, #19, #6,	V 365	b) To, at the time notice is given to schedule a hearing, to notify the clerk the names and addresses of the legal responsible person and the responsible professional; c) to provide three sets copies per set of paperwork and place the paperwork in folders per unit/discharge, and take the paperwork to Clerk of Court office. 3) In order to maintain a record of all notifications of admissions, court date conversations, phone calls, emails, ended to the clerk of courts, lawyers, SRC of the conversations of admissions.	Illy ble of e the
a hearing, the facility names and address person and the responsal formula for the revealed at 2200. "REQUEST FOR HE named facility the inpatient stamp dated (Clerk of Superior Cominor's admission). Interview, on 10/27/2 facility's Court Record	a hearing, the facility shall notify the clerk of the names and addresses of the legally responsible person and the responsible professional " 1. Open medical record review on 10/27/2016 revealed at 2200. Review of Resident #13's "REQUEST FOR HEARING" prepared by the named facility I the inpatient minor revealed a "FILED" stamp dated 2016 by the County C.S.C. (Clerk of Superior Court) days after the		SBC-C has created an excel spreadsheet as a log called the "Communication Log" (Attachment A) This log now encompasses all times reasons for communications between SBC-C and other outside agencies regarding court matters/concerns. 4) SBC-C has also created an excel spreadsheet as a log called the "Court Tracker" (Attachment B) to keep a records of all court initial hearings and hearings for PRTF and Acute units.	and t d re-

RESPONSE CONTINUED ON THE NEXT PAGE

PRINTED: 11/13/2016

Division	of Hoolth Service D	ACCONTRACTOR OF THE PROPERTY O			FORM APPROVED	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601258	B. WING		10/27/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
STRATE	GIC BEHAVIORAL CE	NIER-CHARLOL	ARON ROAD TTE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
V 365	Continued From page	ge 2	V 365	CONTINUATION OF RESPONSE		
Interview with the facility's Director of Quality and Risk, on 10/27/2016 at 1720, revealed the Director was unaware the Clerk of Court was not being notified within 24 hours of new admissions until the Court Record Custodian informed on this day (10/27/2016) had not been performing the task. The Director presented a "Daily Procedure" protocol for court documentation that outlined the process of confirming admissions and notifying the Clerk of Court via telephone of new admissions prior to filing court documents. The Director reported was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and had not been monitoring this process. The Director reported had not received any complaints from the Residents' attorneys regarding late notification. 2. Open medical record review on 10/27/2016 revealed			B. Monitoring System to Ensure Correction of the Problem Compliance with requirement and of correction of the deficiency will monitored as follows: 1) On a daily basis (Monday three Friday), the Compliance/Quality/R Director shall review the list of Admissions of patients against a Communication Log and the Court to ensure that the clerk of court in county where SBC Charlotte is located been notified of a patient admission that a hearing for concurrence in the admission has been scheduled. The findings from this review shall reported to the Hospital's Quality/R		gh k e Tracker e ted has and	
	named facility " " the inpatient stamp dated (Clerk of Superior Cominor's admission). Interview, on 10/27/2 facility's Court Record	d Custodian revealed "The fadmission within 24 hours.		Council Quality/PI Council meeting, monthly Medical Executive Committed meeting and the quarterly Governing meeting at each of their respective meetings. After 100% compliance from months, the frequency of review shadecrease to weekly with reports to the Committees as noted above (Quality Council and MEC – monthly and Goral —quarterly).	the ee g Board or three all ne g/PI	

Divisio	n of Health Service Re	egulation				
1	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 10/27/2016	
		MHL0601258				
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
		1715 SH	IARON ROAD	·		
STRATE	EGIC BEHAVIORAL CE	NIER-CHARLUI	OTTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
V 365	Continued From pa	ge 3	V 365			
	Director was unawa	ire the Clerk of Court was not				
	being notified within	24 hours of new admissions	1			
		ord Custodian informed 📰 or				
	<u> </u>	been performing the task. Th	e			
		a "Daily Procedure" protocol				
		ation that outlined the process				
		sions and notifying the Clerk ne of new admissions prior to				
		nts. The Director reported				
		ession the new Court Record				
	Custodian had been	trained to follow the "Daily	į			
		had not been monitoring this				
	process. The Direct					
	attorneys regarding	aints from the Residents'				
	"REQUEST FOR HE named facility Tan" the inpatient stamp dated (Clerk of Superior Cominor's admission). Interview, on 10/27/2	Review of Resident #11's EARING" prepared by the minor revealed a "FILED" 2016 by the County C.S.C. ourt) days after the 2016 at 1445, with the rd Custodian revealed "The	The state of the s			
		of admission within 24 hours.				
	I've been told we have					
	Interview with the fac Risk, on 10/27/2016	cility's Director of Quality and		;		
		e the Clerk of Court was not				
		24 hours of new admissions	-			
	until the Court Recor	d Custodian informed on		•		
		een performing the task. The	Tanah Tanah			
ivision of He	ealth Service Regulation					

Division	of Health Service Re	egulation			1 OTHER THOUGH
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		10/27/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE	
STRATE	GIC BEHAVIORAL CE	NIFR-LHARIOI	ARON ROAD TTE, NC 282		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 365	Continued From pa	ge 4	V 365		
	Director presented a for court documents of confirming admis of Court via telepho filing court documer was under the impre Custodian had been Procedure" and process. The Direct received any compla attorneys regarding 4. Open medical received at 1700. "REQUEST FOR HE named facility "TO: for" the stamp dated (Clerk of Superior Cominor's admission).	a "Daily Procedure" protocol ation that outlined the process sions and notifying the Clerk ne of new admissions prior to hts. The Director reported session the new Court Record in trained to follow the "Daily had not been monitoring this or reported had not aints from the Residents' late notification. cord review on 10/27/2016 resident (Resident #10) on Review of Resident #10's EARING" prepared by the revealed a "FILED" 2016 by the County C.S.C.			
	facility's Court Recor	d Custodian revealed "The of admission within 24 hours.			
		cility's Director of Quality and at 1720, revealed the			

Division of Health Service Regulation STATE FORM

	$\gamma:=\ell$			FORM APPROVED
Division of Health Service	Regulation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	B. WING		10/27/2016
AVALUE OF PROVINCE OR CURRULE				1 10/2//2016
NAME OF PROVIDER OR SUPPLIE		DDRESS, CITY, ST		
STRATEGIC BEHAVIORAL C	:FNIFR-CHARLOI	ARON ROAD W TTE, NC 2821		
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
V 365 Continued From p	page 5	V 365		
revealed a voluntarily admitte /2016 at 183 "REQUEST FOR I named facility "TO Cour that an initial heari for" the stamp dated (Clerk of Superior minor's admission)	2016 by the County C.S.C. Court) (after the).			
facility's Court Rec court is not notified	/2016 at 1445, with the ord Custodian revealed "The of admission within 24 hours. have seven days"			
	facility's Director of Quality and 6 at 1720, revealed the			

Division of Health Service Regulation STATE FORM

Division	of Health Service Re	egulation			IONWAFFROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		10/27/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
STRATE	GIC BEHAVIORAL CE	NIER-CHARLOI	ARON ROAD V		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETE
V 365	Continued From pa	ge 6	V 365		
	6. Open medical re revealed a voluntarily admitted 2016 at 2200. "REQUEST FOR HE named facility for" the stamp dated (Clerk of Superior C minor's admission). Interview, on facility's Court Record court is not notified of the laterview with the facility with the facility of the stamp with the stamp wi	cord review on			

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION WHLOSO1258 MHLOSO1258 MHLOSO1258 STREET ADDRESS, CITY, STATE, ZIP CODE 10/127/2016 STRATEGIC BEHAVIORAL CENTER-CHARLOT CHARLOTTE, NC 28210 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) PREFIX REQUILATORY OR LSC IDENTIFYING INFORMATION) V 365 Continued From page 7 7. Closed medical record review on resident #15) voluntarily admitted to the mamed facility for "the revealed a record review of resident #15) "REQUEST FOR HEARING" prepared by the named facility Interview, on revealed a record custodian revealed "The court is not notified of admission within 24 hours. I've been told we have seven days" Interview with the facility's Director of Quality and Risk, on 2016 at 1720, revealed the Director was unaware the Clerk of Court was not being notified within 24 hours of new admissions until the Court Record Custodian informed on this day had not been performing the task. The Director presented a "Daily Procedure" protocol	Division of Health Service Re	egulation			. 5(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
NAME OF PROVIDER OR SUPPLIER STRATEGIC BEHAVIORAL CENTER-CHARLOT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 365 Continued From page 7 V 365 7. Closed medical record review on resident (Resident #15) voluntarily admitted to the prepared by the named facility for " the revealed a "FILED" stamp dated 2016 by the County C.S.C. (Clerk of Superior Court) (minor's admission). Interview, on 2016 at 1445, with the facility's Court Record Custodian revealed "The court is not notified of admission within 24 hours. I've been told we have seven days" Interview with the facility's Director of Quality and Risk, on 2016 at 1720, revealed the Director was unware the Clerk of Court was not being notified within 24 hours of new admissions until the Court Record Custodian informed on this day bad not been performing the task. The					
STRATEGIC BEHAVIORAL CENTER-CHARLOT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 365 Continued From page 7 7. Closed medical record review on resident (Resident #15) voluntarily admitted to the mamed facility 1/2016 at 2000. Review of Resident #15's "REQUEST FOR HEARING" prepared by the named facility 1/2016 at 1445, with the facility's Court Record Custodian revealed "The court is not notified of admission within 24 hours. I've been told we have seven days		MHL0601258	B. WING		10/27/2016
CHARLOTTE, NC 28210 (X4) ID PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 365 Continued From page 7 7. Closed medical record review on revealed a resident (Resident #15') voluntarily admitted to the named facility for " the revealed a "FILED" stamp dated 2016 by the County C.S.C. (Clerk of Superior Count) (Impairs admission). Interview, on 2016 at 1445, with the facility's Court Record Custodian revealed "The court is not notified of admission within 24 hours. I've been told we have seven days" Interview with the facility's Director of Quality and Risk, on 2016 at 1720, revealed the Director was unaware the Clerk of Court was not being notified within 24 hours of new admissions until the Court Record Custodian informed on this day 2016 not revealed intormed to the day and not been performing the task. The	NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE, Z	IP CODE	
PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 365 Continued From page 7 7. Closed medical record review on revealed a resident (Resident #15) voluntarily admitted to the stamp dated (Resident #15's "REQUEST FOR HEARING" prepared by the named facility for " the stamp dated (2016 by the County C.S.C. (Clerk of Superior Court) (after the minor's admission). Interview, on (2016 at 1445, with the facility's Court Record Custodian revealed "The court is not notified of admission within 24 hours. I've been told we have seven days " Interview with the facility's Director of Quality and Risk, on (2016 at 1720, revealed the Director was unaware the Clerk of Court was not being notified within 24 hours of new admissions until the Court Record Custodian informed on this day (2016 at not not formed on this day (2016 at not not not not minor make the court was not being notified within 24 hours of new admissions until the Court Record Custodian informed on this day (2016 at not not not not not not not not not no	STRATEGIC BEHAVIORAL CE	NIER-CHARLOI			
7. Closed medical record review on revealed a resident (Resident #15) voluntarily admitted to the 2016 at 2000. Review of Resident #15's "REQUEST FOR HEARING" prepared by the named facility for " the revealed a "FILED" stamp dated 72016 by the County C.S.C. (Clerk of Superior Court) after the minor's admission). Interview, on 72016 at 1445, with the facility's Court Record Custodian revealed "The court is not notified of admission within 24 hours. I've been told we have seven days" Interview with the facility's Director of Quality and Risk, on 72016 at 1720, revealed the Director was unaware the Clerk of Court was not being notified within 24 hours of new admissions until the Court Record Custodian informed 720 on this day 72016 at 1720, revealed the bird on the court Record Custodian informed 7200 on this day 72016 at 1720, revealed the 172	PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX ((EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRO	D BE COMPLETE
revealed a resident (Resident #15) voluntarily admitted to the 72016 at 2000. Review of Resident #15's "REQUEST FOR HEARING" prepared by the named facility for" the revealed a "FILED" stamp dated 72016 by the County C.S.C. (Clerk of Superior Court) after the minor's admission). Interview, on 72016 at 1445, with the facility's Court Record Custodian revealed "The court is not notified of admission within 24 hours. I've been told we have seven days" Interview with the facility's Director of Quality and Risk, on 72016 at 1720, revealed the Director was unaware the Clerk of Court was not being notified within 24 hours of new admissions until the Court Record Custodian informed 72016 at 1720, and the court	V 365 Continued From page	ge 7	V 365		
for court documentation that outlined the process of confirming admissions and notifying the Clerk of Court via telephone of new admissions prior to filing court documents. The Director reported was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and had not been monitoring this process. The Director reported had not received any complaints from the Residents' attorneys regarding late notification. 8. Open medical record review on 1/2016 revealed a resident (Resident #16) yoluntarily admitted	revealed a voluntarily admitted /2016 at 2000. "REQUEST FOR H named facility for" the stamp dated (Clerk of Superior C minor's admission). Interview, on facility's Court Reco court is not notified of I've been told we ha Interview with the far Risk, on /2016 Director was unawar being notified within until the Court Reco this day had not the Director presented a for court documenta of confirming admiss of Court via telephor filing court documen was under the impre Custodian had been Procedure" and process. The Director received any compla attorneys regarding to	resident (Resident #15) to the on Review of Resident #15's EARING" prepared by the revealed a "FILED" 2016 by the County C.S.C. ourt) (County C.S.C. ourt)			

Division of Health Service Regulation

PRINTED: 11/13/2016 FORM APPROVED

Division of Health Service Re	egulatior.			. 0/44//4 / //0725
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	B. WING		10/27/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
STRATEGIC BEHAVIORAL CE	NTER-CHARLOT	RON ROAD W TTE, NC 28210		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
V 365 Continued From page	ge 8	V 365		
"REQUEST FOR HI named facility for" the stamp dated (Clerk of Superior Cominor's admission). Interview, on facility's Court Reconcourt is not notified or ive been told we had linterview with the far Risk, on 2016 Director was unaware being notified within until the Court Reconthis day had not be Director presented a for court documentate of confirming admission of Court via telephor filing court documentate was under the impresented and process. The Director received any complate attorneys regarding to the confirming state of the court of	revealed a "FILED" 2016 by the County C.S.C. ourl) after the 2016 at 1445, with the rd Custodian revealed "The of admission within 24 hours. ve seven days" cility's Director of Quality and at 1720, revealed the re the Clerk of Court was not 24 hours of new admissions rd Custodian informed on oeen performing the task. The a "Daily Procedure" protocol tion that outlined the process sions and notifying the Clerk ne of new admissions prior to ts. The Director reported trained to follow the "Daily had not been monitoring this or reported had not ints from the Residents' attentification.			

Division of Health Service Re	egulation			PRINTED: 11/13/201 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	B. WING		10/27/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
STRATEGIC BEHAVIORAL CEI	NIER-CHARLOI	RON ROAD I		
PRÉFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 365 Continued From pag	je 9	V 365		
(Clerk of Superior Cominor's admission). Interview, on 2/2 facility's Court Record court is not notified of l've been told we have a linterview with the fact Risk, on 2/2016. Director was unaward being notified within a until the Court Record this day he had not be Director presented a for court documentate of confirming admission of Court via telephonic filing court document was under the impression of Court with the court document was under the impression of Court with the court document was under the impression of Court with the court document was under the impression of Court with the court wit	2016 at 1445, with the document of Custodian revealed "The of admission within 24 hours."			

minor's admission). Division of Health Service Regulation STATE FORM

revealed

named facility

for . . ." the

voluntarily admitted

attorneys regarding late notification.

10. Open medical record review on /2016

2016 at 2200. Review of Resident #7's "REQUEST FOR HEARING" prepared by the

stamp dated 2016 by the County C.S.C. (Clerk of Superior Court) (after the

resident (Resident #7)

revealed a "FILED"

Division	of Health Service Re	egulation		***	
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		10/27/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	
STRATE	GIC BEHAVIORAL CE	NTER-CHARLOT	ARON ROAD TTE, NC 282		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
V 365	Continued From pa	ge 10	V 365		
	facility's Court Reco court is not notified I've been told we had Interview with the fa Risk, on 1/2016 Director was unawa being notified within until the Court Reco this day 1/2016 had not Director presented a for court documenta of confirming admiss of Court via telephor filing court document was under the impre Custodian had been Procedure" and process. The Director	cility's Director of Quality and at 1720, revealed the re the Clerk of Court was not 24 hours of new admissions of Custodian informed on been performing the task. The a "Daily Procedure" protocolution that outlined the process sions and notifying the Clerk ne of new admissions prior to the context of the Court Record trained to follow the "Daily had not been monitoring this per reported had not sints from the Residents'			
	voluntarily admitted 2016 at 0915. "REQUEST FOR HE named facility for" the stamp dated (Clerk of Superior Cominor's admission).	resident (Resident #19)			
		d Custodian revealed "The			

court is not notified of admission within 24 hours.

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		10/27/2016
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	
STRATE	GIC BEHAVIORAL CE	NIER-CHARLOI	IARON ROAD I OTTE, NC 282 [,]		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET
V 365	Continued From page	ge 11	V 365		
	I've been told we ha	ive seven days"			
	Risk, on Director was unawa being notified within until the Court Reco this day he had not I Director presented a for court documenta of confirming admiss of Court via telephor filing court documen was under the impre Custodian had been Procedure" and Director The Director of the Custodian had been Process.	cility's Director of Quality and at 1720, revealed the re the Clerk of Court was not 24 hours of new admissions of Custodian informed on been performing the task. The a "Daily Procedure" protocolution that outlined the process sions and notifying the Clerk ne of new admissions prior to its. The Director reported ession the new Court Record trained to follow the "Daily had not been monitoring this per reported had not aints from the Residents' late notification.	e 		
	2016 at 1400. "REQUEST FOR HE named facility for" the stamp dated 2 (Clerk of Superior Co	resident (Resident #6) to the facility's PRTF on Review of Resident #6's EARING" prepared by the revealed a "FILED" 016 by the County C.S.C.			
	facility's Court Record court is not notified o I've been told we hav	ility's Director of Quality and			

PRINTED: 11/13/2016 FORM APPROVED

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0601258	B. WING		10/27/2016
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	
CTDATE	CIC BELLAVIORAL CE	NTER CHARLOT 1715 S	HARON ROAD	WEST	
SIKAIE	GIC BEHAVIORAL CE	NIER-CHARLUI	OTTE, NC 282		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLE HE APPROPRIATE DATE
V 365	Continued From page	ge 12	V 365		
	Director was unawa	- re the Clerk of Court was no			
		24 hours of new admissions			
		rd Custodian informed	i i		
		been performing the task. Th		•	
		"Daily Procedure" protocol	.0		
		ition that outlined the process	6		
		sions and notifying the Clerk			
		ne of new admissions prior to)		
		its. The Director reported			
		ession the new Court Record			
		trained to follow the "Daily			
		had not been monitoring this	ļ.		
		or reported had not			
	attorneys regarding l	aints from the Residents'			
	"REQUEST FOR HE named facility for " the	resident (Resident #14) on Review of Resident #14's EARING" prepared by the revealed the een filed with the County erior Court) (after n).			
		d Custodian revealed "The	No. of the state		
	court is not notified o	f admission within 24 hours.			
	I've been told we hav		4. parameters		
! !	Risk, on //2016 and //	illity's Director of Quality and at 1720, revealed the ethe Clerk of Court was not 24 hours of new admissions d Custodian informed on			
	hic day bad not he	een performing the task. The			

RGLM11

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING MHL0601258 10/27/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1715 SHARON ROAD WEST STRATEGIC BEHAVIORAL CENTER-CHARLOT CHARLOTTE, NC 28210 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 365 Continued From page 13 V 365 Director presented a "Daily Procedure" protocol for court documentation that outlined the process of confirming admissions and notifying the Clerk of Court via telephone of new admissions prior to filing court documents. The Director reported was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and had not been monitoring this process. The Director reported had not received any complaints from the Residents' attorneys regarding late notification. NC00121541

ision of Health Service Regulation

ATE FORM

LAST NAME FIRST NAME REQUESTING
Court Scheduled for 2016



/2016	/2016			2016	2016	2016	-		2016	2016	2016	2016	2016	2016	2016	2016	2016			/2016	/2016	/2016	/2016	/2016	/2016	/2016	/2016	/2016	/2016		pate Revira
T. Carnes	T. Carnes			T. Carnes	T. Carnes	T. Carnes			T. Carnes			T. Carnes		Paviroued BY																	
2016-MY	'2016-MY	2016-MY	2016-MY	2016-MY	016-MY	016-MY	2016-MY	016-MY	1014-MY	014-MY	014-MY	014-MY	2014-MY	1014-MY	014-MY	1014-MY	1014-MY	1014-MY	/2016-MY	/2016-MY	/2016-MY	/2016-MY	/2016-MY	/2016-MY	/2016-MY	/2016-MY	/2016-MY	/2016-MY	/2016-MY	/2016-MY	DOUR Review dotte

			-							2016	2016	2016	2016	2016	2016	2016	2016			2016	2016	2016	2016	2016
										T. Carnes			T. Carnes											
/2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY	2016-MY								

	,									-									
incher to contained	Motion to continue	Dismissed due to miscommunication				DC		DC			DC		Ammended						
			,			DC	Contest	DC	Consent	Contest	DC	Contest	Consent	Consent	Consent	Consent	Consent	Consent	

Sub Air PRO Park Park	Consent		
THE MOIST	DC		DC 10/12
THE MOST			
THE MOST			
THE MOIST	Yes		Continued from 11/1
THE MOIST	Continued		Continued from 11/1
THE MOIST	DC		DC
THE PAPIST			
THE PAPIST			
THE MOIST	Yes		
THE MOIST	Continued		
THE MOIST	Yes		Continued from 10/25
THEMPIST	Yes		Continued from 10/25
THE MIPIST	Yes		
THE MIPIST	Yes		
THE MIPIST	Yes		
THE MIPIST	DC		Review - DC 10/27
THE MIPIST	Continued		
THE MIPIST			
THE MAPIST			
THE MAIPIST	Yes		
THE MAPIST	Continued		
THE MAIPIST	Continued		
THEMPIST	Yes		
THE MAIPIST	Yes		
THEMPIST	Yes		
THE MAIPIST	Yes		
THEMPIST	Yes		
THEMPIST	Yes		
THE MAIDIST	DC		
THEMPIST			
	AT TRUBCHUST	THE MOIST	SUBMIT REQ FOR PEHENNING

"AttachMent A"

DATE	TIME	CALLED (NAME)	TALKED TO:	REASON FOR CALL/Communication (ADMIT, DISCHARGE, COMING TO COURT, ETC)	SBC-C Employee Name
ex	5:15pm-ex	Corp Comp-ex	Miriam-ex		M.Yates
201	16 10:34 AN	1 Clerk of Courts	VM		T. Carnes
201	16 2:26 AN	1 Clerk of Courts	VM		M. Small
201	16 12:00 AN	1 Clerk of Courts	VM		K.Sandidge
201	10:34 AN	1 Clerk of Courts	VM		T. Carnes
201	16 10:21 AN	1 Clerk of Courts	Julie Bailey		T. Carnes
201	16 9:45 AN	1 Clerk of Courts	VM		T. Carnes
201	16 9:27 AN	1 Clerk of Courts	VM		T. Carnes
201	16 9:40 AN	1 Clerk of Courts	VM		T. Carnes
201	16 3:56 PN	1 Clerk of Courts	VM		T. Carnes
201	16 9:25 AN	1 Clerk of Courts	VM		T. Carnes
201	16 8:38 AN	1 Clerk of Courts	VM		T. Carnes
203	12:40 PN	1 Clerk of Courts	VM		T. Carnes
201	16 9:54 AN	1 Clerk of Courts	Julie Bailey		T. Carnes
201	16 3:35PN	1 Clerk of Courts	VM		M. Yates
201	L6 9:53 PN	1 Clerk of Courts	VM		M. Small
202	16 4:31 AN	1 Clerk of Courts	VM		A. Greene
201	16 9:10 AN	1 Clerk of Courts	VM		T. Carnes
202		1 Clerk of Courts	VM		T. Carnes
202	16 8:41 AN	1 Clerk of Courts	VM		T. Carnes
202	16 1·43 PN	1 Clerk of Courts	VM		T. Carnes
201		1 Clerk of Courts	VM		T. Carnes
201		1 Clerk of Courts	VM		T. Carnes
201		1 Clerk of Courts	VM		K. Sandidge
203	16 11:02 AN	1 Clerk of Courts	VM		T. Carnes
202	16 10:09 AN	1 Clerk of Courts	Julie Bailey		T. Carnes
201	1:15 PN	1 Clerk of Courts	VM		L.Ramey
202	16 7:35 PN	1 Clerk of Courts	VM		M. Small

2016	10:43 AM Clerk of Courts	
2016	10:15 AM Clerk of Courts	Julie Bailey
2016	9:05 AM Clerk of Courts	Julie Bailey
2016	11:10 AM Clerk of Courts	VM
2016	8:57 AM Clerk of Courts	VM



1.

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1

Reviewed Date Reviewed By

2016 M.Yates

2014 M.Yates

2014 M.Yates

2014 M.Yates

2014 M.Yates

2014 M.Yates

2016 M.Yates

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/2016 M.Yates /2016 M.Yates /2016 M.Yates /2016 M.Yates M.Yates .2016

MEDICAKE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RGLM12

Pa	ART I - TO	BE COMPI	LETED BY T	HE STA	TE SUR	VEY A	AGENCY		I	acility ID: 9429360	113
MEDICARE/MEDICAID PROVIDER NO. (L1)		3. NAME AND ADDRESS OF FACILITY (L3) STRATEGIC BEHAVIORAL CENTER-CHARLOTTE					4. TYPE OF ACTION: <u>7 (</u> L8)				
2.STATE VENDOR OR MEDICAID NO.	(L	(L4) 1715 SHARON ROAD WEST				Initial	2. Recertification				
(L2)	(L	(L5) CHARLOTTE, NC			(L6) 28210			5.	Termination Validation On-Site Visit	4. CHOW 6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF OWNERS	HIP 7.	PROVIDER/SU	JPPLIER CATEG	ORY	06	(L7)					
(L9)	01	Hospital	05 HHA	09 ESRD	13 PTT	P	22 CLIA	8.	Full Survey After	Complaint	
6. DATE OF SURVEY	(L34) 02	SNF/NF/Dual	06 PRTF	10 NF	14 COR	ι F					
8. ACCREDITATION STATUS: 1	(L10) 03	SNF/NF/Distinct	07 X-Ray	11 ICF/III	15 ASC	:		FISCA	L YEAR ENDIN	IG DATE: (L35))
0 Unaccredited 1 TJC 2 AOA 3 Other	04	SNF	08 OPT/SP	12 RHC	16 HOS	SPICE					
11. LTC PERIOD OF CERTIFICATION	10	10.THE FACILITY IS CERTIFIED AS:									
From (a):	2	X A. In Compliance With			And/Or Approved Waivers Of The Following Requirements:2. Technical Personnel6. Scope of Services Limit						
To (b):		Program Requirements Compliance Based On:									
						3. 24 H			Medical Direction	ector	
12.Total Facility Beds	(L18)	1. A	cceptable POC			4. 7-Da	y RN (Rural	SNF)	8. Patient Room	Size	
•	(L17)	B Not in Com	pliance with Prog	ram	5	5. Life:	Safety Code		Beds/Room		
			and/or Applied V		* Code:	,	A*	(L12)			
14. LTC CERTIFIED BED BREAKDOWN					15. FACI						
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e	e) (1) or	1861 (j) (1):	YES	(L15)		
					(-	, (-,	() (-).		` ,		
(L37) (L38)	(L39)	(L42)	(L43)								
16. STATE SURVEY AGENCY REMARKS (IF	APPLICABLE	SHOW LTC CA	NCELLATION I	DATE):							
A follow up licensure investigation was co	onducted Janu	uary 31, 2017 t	hrough Februar	y 2, 2017.	A deficie	ncy wa	s found un	der NCAC 2	27G .1902 (b) 5	Staffing.	
17. SURVEYOR SIGNATURE		Date:			18. STAT	TE SUR	VEY AGEN	CY APPROV	'AL	Date:	
		0:	2/27/2017	g.10)							
				(L19)							(L20)
	O BE CO	MPLETED E	BY HCFA RE	GIONAL	OFFIC	EOR	SINGLE	STATE A	GENCY		
19. DETERMINATION OF ELIGIBILITY		20. COMPLIANCE WITH CIVIL		I CIVIL					ncial Solvency (HCFA-2572)		
X 1. Facility is Eligible to Participate		RIGHTS ACT:					oth of the Ab		l Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible									-		
	(L21)	7-1-1-7-18-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1							****		
22. ORIGINAL DATE 23. LTC	AGREEMEN	T 24	LTC AGREEM	ENT	26. TER	IAMIMA	TION ACTIO	N:	(I	.30)	
OF PARTICIPATION BEG	GINNING DA	ΓE	ENDING DAT	TE	VOLUNT	TARY	_	00	INVOLUN'	TARY	
					01-Merge	r, Closu	пе		05-Fail to M	leet Health/Safety	
(L24) (L4)	1)		(L25)		02-Dissat	isfaction	n W/ Reimbi	irsement	06-Fail to M	leet Agreement	
	ERNATIVE S	ANCTIONS	()		03-Risk o	f Involu	ntary Termina	ation	OTHER		
					04-Other	Reason	for Withdraw	al		Status Change	
A. Suspension of Admissions: (L44)									00-Active	oming outlings	
(L27) B. Rescind Suspension Date:											
			(L45)								
28. TERMINATION DATE:	29. IN	TERMEDIARY/	CARRIER NO.		30. REM.	ARKS					
00000											
(L28)		20000		(L31)							
(1.20)				(101)							
31. RO RECEIPT OF CMS-1539	32. DE	TERMINATION	OF APPROVAL	DATE							
					DDmn		·///	DD OTT.			
(L32)				(L33)	DETER	MINA	ATION AP	PROVAL			

STATE FORM: REVISIT REPORT PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTRUCTION DATE OF REVISIT IDENTIFICATION NUMBER A. Building MHL0601258 B. Wing 2/3/2017 Y2 YЗ NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE STRATEGIC BEHAVIORAL CENTER-CHARLOTTE 1715 SHARON ROAD WEST CHARLOTTE, NC 28210 This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE Y4 Y5 Y4 Y5 **Y**4 Y5 ID Prefix V0365 Correction **ID Prefix** Correction ID Prefix Correction G.S. 122C-224 Reg. # Completed Reg. # Completed Reg. # Completed LSC 02/03/2017 LSC LSC **ID Prefix** Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC ID Prefix Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC ID Prefix **ID Prefix** Correction Correction ID Prefix Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC ID Prefix Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC REVIEWED BY REVIEWED BY DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) REVIEWED BY REVIEWED BY DATE TITLE CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 10/27/2016 YES NO