DEPARTMENT OF HEALTH AND HUMA[illegible] RVICES — CENTER[illegible]R MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: U9SQ11
Facility ID: 9429360113

1. MEDICARE/MEDICAID PROVIDER NO. (L1)
2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **STRATEGIC BEHAVIORAL CENTER-CHARLOTTE**
(L4) **1715 SHARON ROAD WEST**
(L5) **CHARLOTTE, NC** (L6) **28210**

4. TYPE OF ACTION: 6 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/03/2017** (L34)

8. ACCREDITATION STATUS: 1 (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 06 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP
02 SNF/NF/Dual	06 LAB	10 NF	14 CORF
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE

FISCAL YEAR ENDING DATE: (L35)

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): **YES** (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

A licensure complaint investigation was conducted January 31, 2017 throguh Feburary 3, 2017. A deficiency was cited under 10 NCAC 27G .1902 (b) Staffing. NC00123945, NC00123747, NC00123722, NC00123717, NC00124277, NC00124471, NC0012453

17. SURVEYOR SIGNATURE [redacted] Date: 02/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH AND HUMA[illegible]RVICES — CENTER[illegible]R MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: U9SQ11

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Facility ID: 9429360113

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(L3) **STRATEGIC BEHAVIORAL CENTER-CHARLOTTE**
(L4) **1715 SHARON ROAD WEST**
(L5) **CHARLOTTE, NC** (L6) **28210**

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18 SNF	18/19 SNF	19 SNF	ICF	IMR
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A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00000** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Division of Health Service Regulation

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

3/27/17 OM

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 315	.1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction of a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the facility is hospital based, staff shall be specifically assigned to this program, with responsibilities clearly separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse. This Rule is not met as evidenced by: Based on facility policy review, medical record review, shift report review, staffing schedule review, facility investigative reports review and staff interview, the facility failed to have at least two direct care staff members present with every six residents at all times for 7 of 10 sampled night shifts reviewed (12/15/2016, 12/18/2016, 12/20/2016, 01/23/2017, 01/29/2017, 01/30/2017 and 01/31/2017). The findings include: Review of the facility's "Staffing Ratio" policy dated as reviewed/revised 12/2016 revealed "Nursing care is provided twenty-four hours a day, seven days a week and is based on client census	V 315	A. Corrective Actions Pursuant to the findings, the following actions were taken by Strategic Behavioral Center, Charlotte (SBC-C): 1.) In order to ensure compliance with the 2:6 ratio of direct care staff to patients, SBC-C hired an additional Residential Counselor for the third shift. 2.) The Director of Nursing and Milieu Manager held retraining with all residential nursing staff on the following content: a. The expectation that any precautions or higher level observations are communicated to Residential Counselors and Staffing Coordinator. b. Expectations on supervision of hallways. c. The requirement that at least two direct care staff shall be present with every six children or adolescents in each residential unit. d. The procedure for the completion of staffing sheets. e. The requirements specific to 1:1, close observation, and one to one status. 3.) Monthly Supervision training is now being held with each month to include topics including but not limited to patient boundaries, restrictive interventions, Q15 documentation, to include the new addition of 2:6 audit tool and updated staffing grid (see reference A and B), supervision, and levels of observation. 4.) Schedule gaps whereby the 2:6 staff to patient ratio cannot be met with the core and PRN staff are now being filled by the Milieu Manager and Staffing Coordinator who are now required to come in to work those gaps. B. Monitoring system that has been or will be implemented including the person(s) responsible for the monitoring to ensure compliance: 1.) Daily audits of staffing assignment sheets are now being conducted to ensure that the required facility staffing ratio is being maintained.	3/17/17

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

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STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

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V 315	Continued From page 1 and acuity. Staffing patterns are intended to serve only as a guideline and may be adjusted to meet individual client care needs. The minimum staffing ratio for resident advisors will be 2:6. ..." 1. Closed medical record review of Resident #9 revealed a [redacted] Review revealed the resident [redacted] Review of a "Resident Observation Record" dated [redacted]/2016 third shift revealed documentation of [redacted] Open medical record review of Resident #10 revealed a [redacted] Review of a "Resident Observation Record" dated [redacted] 2016 third shift revealed documentation of [redacted] Review of Facility Shift Report for night shift on [redacted]/2016 revealed Resident #9 [redacted] Review of Facility Shift Report for night shift on [redacted] 2016 revealed Resident #10 [redacted] 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	V 315	2.) An assessment of compliance with the maintenance of the required 2:6 staffing ratio on the Residential Care units is now being conducted through random visual checks in person and per camera. 3.) The Staffing Coordinator now communicates with the CEO on a Monday through Friday basis to notify same of the staffing schedule and any staffing needs. 4.) A summary of the compliance with maintenance of the 2:6 staffing ratio on the Residential Care Units is now being reported at the monthly Quality/ Performance Improvement Meeting, the Medical Executive Committee and Governing board at each of their respective meetings. Responsible Person: Milieu Manager	3/17/2017

3-16-17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 315	Continued From page 2 consistent with the policy requirement of 2 staff to 6 residents). Review of the video revealed Resident #9 [redacted] 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 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	V 315		

3-16-17

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V 315	Continued From page 3 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 [redacted] Review of "Resident Observation Record" dated [redacted] 2016 revealed documentation of patient [redacted] 2016 through [redacted] 2016 at [redacted] "Resident Observation Record" revealed [redacted] No issues to report." Review of Facility Shift Report for night shift on [redacted] 2016 revealed [redacted] 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. Further review of daily assignment sheets	V 315		

3-16-17

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V 315	Continued From page 4 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. 3. Review of "Resident Observation Record" dated [redacted]/2017 revealed documentation of [redacted] "Resident Observation Record" revealed documentation on evening shift "E (evaluation) Resident [redacted]	V 315		

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V 315	Continued From page 5	V 315		

[redacted]

Review of Facility Shift Report for evening shift on 12/20/2016 revealed "Resident [redacted]

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

3-16-17

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V 315	Continued From page 6 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 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 12/20/2017 was not consistent with the facility policy of two staff members for every six residents. 4. Review of staffing schedule dated 01/23/2017 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	V 315		

3-16-17

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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 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 01/29/2017 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 there were a total of 34 residents on the 100, 200 & 300 units during the night shift. Review of daily assignment sheet for 01/30/2017 revealed 1	V 315		

3-16-17

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 315	Continued From page 8 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 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	V 315		

3-1617

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 315	Continued From page 9 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	V 315		

3-16-17

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
A unit consists of two patient halls joined by a nursing station with exception of 100, 300, and 400 halls whereby one hall is Acute and one PRTF. Acute Units: 400,500 PRTF Units: 100,200,300							
100	RN						
	LVN						
	MHT						
200	RN						
	LVN						
	MHT						
700	RN						
	LVN						
	MHT						
800	RN						
	LVN						
	MHT						
300	RN						
	LVN						
	MHT						
400	RN						
	LVN						
	MHT						
500	RN						
	LVN						
	MHT						
600	RN						
	LVN						
	MHT						

Comments:

_____

_____

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

Unit/Area	Shift/time	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
2017	DATE:							
PRTF UNITS/PATIENT AREA								
100	DAYS							
	EVES							
	NOCS							
200	DAYS							
	EVES							
	NOCS							
300	DAYS							
	EVES							
	NOCS							
400	DAYS							
	EVES							
	NOCS							
500	DAYS							
	EVES							
	NOCS							
CAFETERIA	DAYS							
CAFETERIA	PM							
REC ROOM								
COURTYARD								
CLASSROOM								

Name of Auditor/Title/Date/Time

_____ _____

_____ _____

_____ _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W9JR11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 9429360113

1. MEDICARE/MEDICAID PROVIDER NO. (L1)

2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **STRATEGIC BEHAVIORAL CENTER-CHARLOTTE**
(L4) **1715 SHARON ROAD WEST**
(L5) **CHARLOTTE, NC** (L6) **28210**

4. TYPE OF ACTION: **6** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/21/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **06** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP
02 SNF/NF/Dual	06 LAB	10 NF	14 CORF
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE

FISCAL YEAR ENDING DATE: (L35)
12/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

A complaint investigation was conducted at the facility September 19-21, 2017. A deficiency was cited in State Licensure for Mental Health/Substance Abuse for HCPR-24 Hour Reporting 130 .0102 . A plan of correction was requested from the facility. NC00131494, NC00131571, NC00131034, NC00131457, and NC00131573.

17. SURVEYOR SIGNATURE [redacted] Date: 10/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
___ 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	A. BUILDING: _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on resident family interview, policies and procedures, internal investigation review, medical record review, and staff interview, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of the allegation for 1 of 2 sampled patients that alleged staff abuse (Patient #1). Findings included: A telephone interview with resident #1's [redacted] was done on 09/21/2017 at 1110 per [redacted] request to facility. The interview revealed that the mother was upset that [redacted] had learned on [redacted]/2017 that resident #1 had reported to [redacted] being slapped by a staff member after [redacted] The [redacted] reported [redacted] was called by the facility staff on [redacted]/2017) and told about [redacted] but was not told about the alleged slap. The interview revealed that the [redacted] just	V 318	Please note that the response is being prepared in the following format: a) *the processes that led to the deficiency cited; b) The procedure for implementing the acceptable plan of correction for the specific deficiency cited; c)The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/ or in compliance with the regulatory requirements. d)The title of the person responsible for implementing the acceptable plan of correction; e)The date by which all corrective action will be completed and the monitoring system will be in place* a)Corrective Actions The report of the allegation of a staff 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 including allegations of staff-to- resident abuse and the associated reporting requirements related to such allegations including the report is to be submitted within 24 hours of becoming aware of the allegation.(2)Effective immediately , to ensure compliance with the requirement for DQCR to report an allegation of staff-to-resident abuse within 24 hours of becoming aware,100% of patient verbal report or external complaints received will be presented by the DQCR to the CEO (and in his absence the Regional VP) on a M through F basis to ensure that timeliness of the reports to DQCR is occurring. This process will be conducted on an ongoing basis. Failure to follow procedure and timeliness of submission of reports to the HCPR will be addressed through the progressive disciplinary process. c) Monitoring Procedure. The results of all investigations as well as the DQCR's compliance with timeliness of reporting events to the HCPR within 24 hours of the facility becoming aware including injuries of unknown source, will be reported by the DQCR to the Quality/PI Council, the Medical Executive Committee, and the Governing Board at each of their respective meetings on a monthly basis. If at 100% compliance for four consecutive months, the frequency for reporting to the Committees will reduce to quarterly. d) Responsible Person. Director of Quality, Compliance, Risk Management (DQCR).	e) 10/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	A. BUILDING: _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 318	Continued From page 1 wanted to have a thorough investigation completed. Review on 09/21/2017 of facility's policy, "Abuse Neglect or Exploitation", Policy No.: CS 1200.9, revised, 12/2016, revealed "d. The Director of Risk Management will complete a full investigation of all allegations and file a report with the following agencies outlining the suspected allegations, the investigative summary, outcome and prevention steps taken to resolve the investigation. Reporting to agencies: ...Health Care Personnel Registry ...§122C-66. Protection from abuse and exploitation; reporting. ...(b) Any employee of (facility name) who witnesses or has knowledge of a violation subsection (a) ...shall report the violation ...to his immediately [sic] supervisor or the [sic] a member of the Clinical Team." Review on 09/21/2017 of the internal investigation of resident #1's statement dated [redacted]/2017 revealed: [redacted] An open medical record review for resident #1 revealed [redacted] Review of the record revealed [redacted]	V 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	A. BUILDING: _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 318	Continued From page 2 [redacted] The documentation revealed [redacted] No documentation was found in the record that the resident alleged that [redacted] was hit by staff. Interview on 09/21/2017 at 1205 with the facility's DQCR (Quality/Risk Management) revealed: [redacted] NC00131494; NC00131571; NC00131034; NC00131451; NC00130219; NC00131573	V 318		

[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4IND11

Facility ID: 9429360113

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO. (L1)

2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **STRATEGIC BEHAVIORAL CENTER-CHARLOTTE**
(L4) **1715 SHARON ROAD WEST**
(L5) **CHARLOTTE, NC** (L6) **28210**

4. TYPE OF ACTION: **6** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **06** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___ 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): **YES** (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE [redacted] Date: 07/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL [redacted] Date: 8/4/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00000** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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 | Approved: 7.31.17

REC'D JUL 18 2017

PRINTED: 07/05/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9429360113	A. BUILDING _____ B. WING _____	C 05/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 207	483.374(b) FACILITY REPORTING Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported include; - a resident's death; - a serious injury to a resident as defined in section §483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include - the name of the resident involved in the serious occurrence, - a description of the occurrence and, - the name, street address, and telephone number of the facility. This ELEMENT is not met as evidenced by: Based on North Carolina Administrative Code (NCAC) and General Statutes (GS) reviews, facility policy review, medical record review, facility investigative findings, and staff interviews, the facility staff failed to report an attempted suicide (Level II incident) to the State Medicaid agency and the Protection and Advocacy system for 1 of 1 sampled residents (Resident #1). The findings include: Review on 05/04/2017 of North Carolina Administrative Code revealed, "10A NCAC	N 207	Please note that the response is being preared in the following format: (a) A description of the corrective action(s) and the systems that have been or will be implemented to correct the deficiencies. (b) A description of the monitoring system that has been or will be implemented. (c) Implementation date Pursuant to this finding, the following actions have been taken: 483.374(b) Facility Reporting (a) Corrective actions (1)The Director of Compliance/Quality/Risk (DCQR), the Director of Nursing and the CEO have been educated through face to face discussion and telephone conference with the Corporate Compliance Officer on the associated reporting requirement that 100% of serious occurrences involving a resident are to be reported to the State designated Protection and Advocacy system by the Director of Compliance/ Quality/Risk in accordance with the required time frames and content. (2) A system has been established whereby all patient occurrences will be discussed on a Monday through Friday basis (with events occurring on Friday, Saturday, and Sunday Incorporated into Monday's report) at the Hospital's Patient Safety Committee meeting. All occurrences deemed as serious occurrences shall be reported to the State Medicaid agency and the state designated Protection and Advocacy system no later than close of business the next business day after the serious occurrence.	(c) 06/01/17

LABORATOR[redacted]NATURE | TITLE CEO | (X6) DATE 7-17-17

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.

RECEIVED JUL 20 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9429360113	A. BUILDING _____ B. WING _____	C 05/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 207	Continued From page 1 27G.0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents....that occur during the provision of billable services or while the consumer is on the providers premises....within 72 hours of becoming aware of the incident." Review on 05/04/2017 of the North Carolina Division of Mental Health, Developmental Disabilities, and Substances Abuse Services 2011 "Incident Response and Reporting Manual" revealed, "....C. Incident Categories....7. Consumer Behavior: Report any....destructive behavior that results in....or a potentially serious threat to the health or safety of self or others." Review on 05/01/2017 of the facility's "Care of Patient", Policy Number 1300.07 reviewed/revised 12/2016, " ...Patients at risk for suicide ....require ...close observation .... Heightened Observations: 1...Patients who are assessed to be at moderate or high risk for suicidality may be placed on.... or on a one to one (1:1) observation status as outlined in the Level of Observation policy. Review on 05/01/2017 of the facility's "Level of Patient Observation", Policy No: NS 1300.41 reviewed/revised 12/2016 revealed, " ...One to One Observation: This the only and sole assignment of one staff member .... The staff member assigned is in constant visual range of the client ... and is within arm's length of the client at all times ...Procedure...a. Any resident on 1:1 ....will be evaluated daily." Review on 05/01/2017 of the facility's "Incident	N 207	b. Monitoring system (1)To ensure compliance with this requirement, 100% of occurrences reported through the incident reporting system and through shift report will be audited by the Safety Committee daily 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 the DCQR on a Monday through Friday basis 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/PI Council, the Medical Executive Committee and the Governing Board at each of its respective meetings through year-end, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9429360113	A. BUILDING _____ B. WING _____	C 05/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 207	Continued From page 2 Reporting Policy", Policy No: RM 1600.3 reviewed/revised 12/2016, revealed, "Policy: ... (Facility name) shall also provide open and timely reporting of incidents as required by CARF (Commission on Accreditation of Rehabilitation Facilities), local, state, and federal entities. ...Incidents - Any unusual or unexpected occurrence that results in injury or potential injury to patients ...K. The Director of Risk Management and Compliance shall be responsible for reporting or notification of incidents to external entities as defined by regulation or standard. ..." Open medical record review on 05/01/2017 for Resident #1 revealed [redacted] Review of daily nursing progress notes revealed [redacted] Review of physician orders by MD [redacted] on [redacted] 2017 at [redacted] revealed [redacted] Review of an "EVALUATION OF RISK" performed by LP [redacted] on [redacted] 2017 at [redacted] revealed [redacted] Review of a physician's progress note by MD [redacted] on [redacted] 2017 at [redacted] revealed, [redacted] " Further review failed to reveal additional information [redacted]	N 207		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9429360113	A. BUILDING _____ B. WING _____	C 05/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 207	Continued From page 3 [redacted] Review on 05/02/2017 of a document provided by the director of quality, compliance and risk (DQCR) on [redacted]2017 at [redacted]revealed a progress note by RN [redacted] Review revealed, "(Resident name) [redacted] Review revealed [redacted] Review revealed, [redacted]." Review of another entry by RN [redacted] [redacted]2017 at [redacted] revealed, [redacted] Interview on [redacted]/2017 at [redacted] with the DQCR revealed [redacted] Interview revealed [redacted] Interview revealed the resident's [redacted] Interview revealed [redacted] [redacted] Interview on [redacted]/2017 at [redacted] with the DQCR revealed [redacted]	N 207		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9429360113	A. BUILDING _____ B. WING _____	C 05/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 207	Continued From page 4 [redacted]	N 207		

[redacted]

Interview on [redacted]/2017 at 1605 with RN [redacted] revealed MHT [redacted] presented to the nursing station and asked her to come with him to evaluate Resident [redacted] status. Interview revealed [redacted] Interview revealed [redacted] Interview revealed [redacted] Interview revealed the [redacted]

Interview on [redacted]2017 at 1715 with MHT [redacted] revealed he was assigned to the hall Resident #1 stayed on. Interview revealed [redacted] Interview revealed the resident [redacted]

An interview with the chief executive officer (CEO) and DQCR on [redacted]2017 at 0845 revealed, [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9429360113	A. BUILDING _____ B. WING _____	C 05/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 207	Continued From page 5 [redacted] Interview revealed [redacted] Telephone interview on 05/24/2017 at 1045 with Department Staff #1 with the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NCDHHS: MHDDSAS) Advocacy and Customer Services revealed there was no report on file by the facility regarding [redacted] involving Resident #1 to date. Interview revealed the facility is required to report "all level II incidents" as outlined in 10A NCAC 27G.0604. Interview revealed the facility staff failed to report [redacted] to the State Medicaid agency. NC00127165, NC00127663, and NC00127669	N 207		

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SHHU11

Facility ID: 9429360113

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO. (L1)

2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **STRATEGIC BEHAVIORAL CENTER-CHARLOTTE**
(L4) **1715 SHARON ROAD WEST**
(L5) **CHARLOTTE, NC** (L6) **28210**

4. TYPE OF ACTION: **6** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/21/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER SUPPLIER CATEGORY **06** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP
02 SNF/NF/Dual	06 LAB	10 NF	14 CORF
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE

FISCAL YEAR ENDING DATE: (L35)
12/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10 THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers * Code. **A*** (L12)

And Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
A complaint investigation was conducted at the facility September 19-21, 2017. No deficiencies were found during the investigation. NC00131219.

17. SURVEYOR SIGNATURE [redacted] Date: 10/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL [redacted] Date: 10/12/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above:

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date. (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W. Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY CARRIER NO. **00000** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9429360113	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments No deficiencies were found during the complaint investigation conducted 09/19/2017 through 09/21/2017. NC00130219.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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

ID: RNYN11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 150460

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **344031**
2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **STRATEGIC BEHAVIORAL CENTER-CHARLOTTE**
(L4) **1715 SHARON ROAD WEST**
(L5) **CHARLOTTE, NC** (L6) **28210**

4. TYPE OF ACTION: **6** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/21/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 NOT ACCREDITED 1 JC
2 AOA/HFAP 3 DNV GL
4 TJC & AOA 5 DNV GL
6 DNV & TJC 7 DNV & AOA
8 DNV, TJC, & AOA 9 CIHQ

7. PROVIDER/SUPPLIER CATEGORY **01** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP
02 SNF/NF/Dual	06 LAB	10 NF	14 CORF
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE

FISCAL YEAR ENDING DATE: (L35)
12/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
A complaint investigation was conducted at the hospital September 19-21, 2017. No deficiencies were found during the investigation. NC00131317.

17. SURVEYOR SIGNATURE [redacted] Date: 10/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
___ 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE: (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344031	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOTTE	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS No deficiencies were found during the complaint investigation conducted at the hospital on 09/19/2017 through 09/21/2017. NC00131317.	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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

ID: RGLM11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 9429360113

1. MEDICARE/MEDICAID PROVIDER NO. (L1)

2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **STRATEGIC BEHAVIORAL CENTER-CHARLOTTE**
(L4) **1715 SHARON ROAD WEST**
(L5) **CHARLOTTE, NC** (L6) **28210**

4. TYPE OF ACTION: 7 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: 1 (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 06 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: A* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): **YES** (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOWLTC CANCELLATION DATE):
A follow up survey and state licensure complaint investigation was conducted October25-27, 2016 to investigate the facility's compliance with NC Rules Governing Psychiatric Rehabilitatoin Treatment Faclilitys (PRTF). A deficiency in Judicial Review of Voluntary Admission was cited as a result of the investigtation NC00121541

17. SURVEYOR SIGNATURE Date: 11/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency(HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above:

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	A. BUILDING: _____ B. WING _____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

12/12/16 dm

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 365	G.S. 122C-224 Judicial Review of Voluntary Admission § 122C-224. JUDICIAL REVIEW OF VOLUNTARY ADMISSION. (a) When a minor is admitted to a 24-hour facility where the minor will be subjected to the same restrictions on his freedom of movement present in the State facilities for the mentally ill, or to similar restrictions, a hearing shall be held by the district court in the county in which the 24-hour facility is located within 15 days of the day that the minor is admitted to the facility. A continuance of not more than five days may be granted. (b) Before the admission, the facility shall provide the minor and his legally responsible person with written information describing the procedures for court review of the admission and informing them about the discharge procedures. They shall also be informed that, after a written request for discharge, the facility may hold the minor for 72 hours during which time the facility may apply for a petition for involuntary commitment. (c) Within 24 hours after admission, the facility shall notify the clerk of court in the county where the facility is located that the minor has been admitted and that a hearing for concurrence in the admission must be scheduled. At the time notice is given to schedule a hearing, the facility shall notify the clerk of the names and addresses of the legally responsible person and the responsible professional. (1975, c. 839; 1977, c. 756; 1979, c. 171, s. 1; 1983, c. 889, ss. 1, 2; 1985, c. 589, s. 2; 1987, c. 370, s. 1.) This Rule is not met as evidenced by: Based on review of the North Carolina General	V 365	**A. Corrective Actions** Pursuant to the findings, the following actions were taken by Strategic Behavioral Center, Charlotte (SBC-C): 1) SBC-C has hired and has fully trained a full time employee to serve as the "Court Record Custodian". The Court Records Custodian handles all the paperwork for both the PRTF and Acute units and other duties/ daily processes which established by SBC-C and SBC-C attorney. 2) This new Court Record Custodian has received competency training specific to his role. As part of his training, the Court Records Custodian has been specifically instructed to, in order to ensure that a hearing for concurrence in the admission of the patient has been scheduled: a)To, within 24 hours after admission , notify the clerk of court in the county where the facility is located that a minor has been admitted to the Acute or PRTF Units and that a hearing for concurrence in the admission is scheduled; RESPONSE CONTINUED ON THE NEXT PAGE	**C.** 12/2/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	A. BUILDING: _____ B. WING _____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 365	Continued From page 1	V 365	CONTINUATION OF RESPONSE	C. 12/2/2016

Statutes (N.C.G.S.), medical records, "REQUEST FOR HEARING" documents, and staff interviews, facility staff failed to notify the clerk of court within 24 hours of a minor's admission to a Psychiatric Residential Treatment Facility (PRTF) pursuant to N.C.G.S. for 13 of 13 sampled residents (#13, #2, #11, #10, #12, #18, #15, #16, #17, #7, #19, #6, and #14).

Findings include:

Review of N.C.G.S. "Chapter 122C - Article 5 . . . 122C-224. Judicial review of voluntary admission." revealed, ". . . (c) Within 24 hours after admission, the facility shall notify the clerk of court in the county where the facility is located that the minor has been admitted and that a hearing for concurrence in the admission must be scheduled. At the time notice is given to schedule 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 [redacted] at 2200. Review of Resident #13's "REQUEST FOR HEARING" prepared by the named facility [redacted]" the inpatient minor revealed a "FILED" stamp dated [redacted] 2016 by the County C.S.C. (Clerk of Superior Court) [redacted] days after the minor's admission).

Interview, on 10/27/2016 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 . . ."

b) To, at the time notice is given to schedule a hearing, to notify the clerk of the names and addresses of the legally responsible person and the responsible professional; c) to provide three sets of copies per set of paperwork and place the paperwork in folders per unit/ discharge, and take the paperwork to the Clerk of Court office.

3) In order to maintain a record of all notifications of admissions, court dates, conversations, phone calls, emails, etc. between the clerk of courts, lawyers, etc., SBC-C has created an excel spreadsheet as a log called the "Communication Log" (Attachment A). This log now encompasses all times and 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 re-hearings for PRTF and Acute units.

RESPONSE CONTINUED ON THE NEXT PAGE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	A. BUILDING: _____ B. WING _____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 365	Continued From page 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 [redacted] on this day (10/27/2016) [redacted] 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 [redacted] was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and [redacted] had not been monitoring this process. The Director reported [redacted] had not received any complaints from the Residents' attorneys regarding late notification.

2. Open medical record review on 10/27/2016 revealed [redacted] Review of Resident #2's "REQUEST FOR HEARING" prepared by the named facility "[redacted] . . ." the inpatient minor revealed a "FILED" stamp dated [redacted] 2016 by the County C.S.C. (Clerk of Superior Court) ([redacted] days after the minor's admission).

Interview, on 10/27/2016 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 10/27/2016 at 1720, revealed the

B. Monitoring System to Ensure Correction of the Problem — **C. 12/2/2016**

Compliance with requirement and evidence of correction of the deficiency will be monitored as follows:

1) On a daily basis (Monday through Friday), the Compliance/Quality/Risk Director shall review the list of Admissions of patients against the Communication Log and the Court Tracker to ensure that the clerk of court in the county where SBC Charlotte is located has been notified of a patient admission and that a hearing for concurrence in the admission has been scheduled.

The findings from this review shall be reported to the Hospital's Quality/PI Council Quality/PI Council meeting, the monthly Medical Executive Committee meeting and the quarterly Governing Board meeting at each of their respective meetings. After 100% compliance for three months, the frequency of review shall decrease to weekly with reports to the Committees as noted above (Quality/PI Council and MEC – monthly and Governing Board –quarterly).

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	MHL0601258	A. BUILDING: _____ B. WING _____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 365	Continued From page 3	V 365		

Director was unaware the Clerk of Court was not being notified within 24 hours of new admissions until the Court Record Custodian informed [redacted] on this day [redacted] 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 [redacted] was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and [redacted] had not been monitoring this process. The Director reported [redacted] had not received any complaints from the Residents' attorneys regarding late notification.

3. Open medical record review on 10/27/2016 revealed [redacted] Review of Resident #11's "REQUEST FOR HEARING" prepared by the named facility [redacted] . ." the inpatient minor revealed a "FILED" stamp dated [redacted] 2016 by the County C.S.C. (Clerk of Superior Court) [redacted] days after the minor's admission).

Interview, on 10/27/2016 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 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 [redacted] on this day [redacted] had not been performing the task. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	A. BUILDING: _____ B. WING _____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 365	Continued From page 4	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 [redacted] was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and [redacted] had not been monitoring this process. The Director reported [redacted] had not received any complaints from the Residents' attorneys regarding late notification.

4. Open medical record review on 10/27/2016 revealed [redacted] resident (Resident #10) voluntarily admitted [redacted] on [redacted]/2016 at 1700. Review of Resident #10's "REQUEST FOR HEARING" prepared by the named facility "TO: [redacted] for . . ." the [redacted] revealed a "FILED" stamp dated [redacted]/2016 by the County C.S.C. (Clerk of Superior Court) ([redacted] after the minor's admission).

Interview, on [redacted]/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 [redacted]/2016 at 1720, revealed the [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	A. BUILDING: _____ B. WING _____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 365	Continued From page 5	V 365		

[redacted]

5. Open medical record review on [redacted]/2016 revealed a [redacted] resident (Resident #12) voluntarily admitted to the [redacted] on [redacted]/2016 at 1830. Review of Resident #12's "REQUEST FOR HEARING" prepared by the named facility "TO: Clerk of Superior Court of [redacted] County This serves as official notice that an initial hearing . . . needs to be scheduled for . . ." the [redacted] revealed a "FILED" stamp dated [redacted]/2016 by the County C.S.C. (Clerk of Superior Court) ([redacted] after the minor's admission).

Interview, on [redacted]/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 [redacted]/2016 at 1720, revealed the [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 365	Continued From page 6	V 365		

[redacted]

6. Open medical record review on [redacted]/2016 revealed a [redacted] resident (Resident #18) voluntarily admitted to the [redacted] on [redacted]/2016 at 2200. Review of Resident #18's "REQUEST FOR HEARING" prepared by the named facility [redacted] for . . ." the [redacted] revealed a "FILED" stamp dated [redacted]2016 by the County C.S.C. (Clerk of Superior Court) [redacted] after the minor's admission).

Interview, on [redacted]/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 [redacted]/2016 at 1720, revealed the [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	A. BUILDING: _____ B. WING _____	10/27/2016

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STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 365	Continued From page 7	V 365		

7. Closed medical record review on [redacted]/2016 revealed a [redacted] resident (Resident #15) voluntarily admitted to the [redacted] on [redacted]/2016 at 2000. Review of Resident #15's "REQUEST FOR HEARING" prepared by the named facility [redacted] for . . ." the [redacted] revealed a "FILED" stamp dated [redacted]/2016 by the County C.S.C. (Clerk of Superior Court) ([redacted] after the minor's admission).

Interview, on [redacted]/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 [redacted]/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 [redacted] on this day [redacted] 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 [redacted] was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and [redacted] had not been monitoring this process. The Director reported [redacted] had not received any complaints from the Residents' attorneys regarding late notification.

8. Open medical record review on [redacted]/2016 revealed a [redacted] resident (Resident #16) voluntarily admitted [redacted] on [redacted]/2016 at 2200. Review of Resident #16's

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"REQUEST FOR HEARING" prepared by the named facility [redacted] for . . ." the [redacted] revealed a "FILED" stamp dated [redacted] 2016 by the County C.S.C. (Clerk of Superior Court) [redacted] after the minor's admission).

Interview, on [redacted] 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 [redacted] /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 [redacted] on this day [redacted] 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 [redacted] was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and [redacted] had not been monitoring this process. The Director reported [redacted] had not received any complaints from the Residents' attorneys regarding late notification.

9. Open medical record review on [redacted] /2016 revealed a [redacted] resident (Resident #17) voluntarily admitted [redacted] on [redacted] 2016 at 1400. Review of Resident #17's "REQUEST FOR HEARING" prepared by the named facility [redacted]

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STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 365	Continued From page 9	V 365		

for . . ." the [redacted] revealed a "FILED" stamp dated [redacted]/2016 by the County C.S.C. (Clerk of Superior Court) ([redacted] after the minor's admission).

Interview, on [redacted]/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 [redacted]/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 [redacted] on this day he 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 [redacted] was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and [redacted] had not been monitoring this process. The Director reported [redacted] had not received any complaints from the Residents' attorneys regarding late notification.

10. Open medical record review on [redacted]/2016 revealed [redacted] resident (Resident #7) voluntarily admitted [redacted] on [redacted]/2016 at 2200. Review of Resident #7's "REQUEST FOR HEARING" prepared by the named facility [redacted]

for . . ." the [redacted] revealed a "FILED" stamp dated [redacted]/2016 by the County C.S.C. (Clerk of Superior Court) ([redacted] after the minor's admission).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601258	A. BUILDING: _____ B. WING _____	10/27/2016

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STRATEGIC BEHAVIORAL CENTER-CHARLOT	1715 SHARON ROAD WEST CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 365	Continued From page 10	V 365		

Interview, on [redacted]/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 [redacted]/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 [redacted] on this day [redacted] 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 [redacted] was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and [redacted] had not been monitoring this process. The Director reported [redacted] had not received any complaints from the Residents' attorneys regarding late notification.

11. Open medical record review on [redacted]/2016 revealed [redacted] resident (Resident #19) voluntarily admitted [redacted] on [redacted] 2016 at 0915. Review of Resident #19's "REQUEST FOR HEARING" prepared by the named facility [redacted] for . . ." the [redacted] revealed a "FILED" stamp dated [redacted]/2016 by the County C.S.C. (Clerk of Superior Court) ([redacted] after the minor's admission).

Interview, on 10/27/2016 at 1445, with the facility's Court Record Custodian revealed "The court is not notified of admission within 24 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 365	Continued From page 11	V 365		

I've been told we have seven days . . ."

Interview with the facility's Director of Quality and Risk, on [redacted]/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 [redacted] on this day he 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 [redacted] was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and [redacted] had not been monitoring this process. The Director reported [redacted] had not received any complaints from the Residents' attorneys regarding late notification.

12. Open medical record review on [redacted]2016 revealed [redacted] resident (Resident #6) voluntarily admitted to the facility's PRTF on [redacted]2016 at 1400. Review of Resident #6's "REQUEST FOR HEARING" prepared by the named facility [redacted] for . . ." the [redacted] revealed a "FILED" stamp dated [redacted]/2016 by the County C.S.C. (Clerk of Superior Court) ([redacted] after the minor's admission).

Interview, on [redacted]/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 [redacted]/2016 at 1720, revealed the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 365	Continued From page 12	V 365		

Director was unaware the Clerk of Court was not being notified within 24 hours of new admissions until the Court Record Custodian informed [redacted] on this day [redacted] 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 [redacted] was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and [redacted] had not been monitoring this process. The Director reported [redacted] had not received any complaints from the Residents' attorneys regarding late notification.

13. Open medical record review on [redacted]/2016 revealed [redacted] resident (Resident #14) voluntarily admitted [redacted] on [redacted] 2016 at 2300. Review of Resident #14's "REQUEST FOR HEARING" prepared by the named facility [redacted] for . . ." the [redacted] revealed the document had not been filed with the County C.S.C. (Clerk of Superior Court) ([redacted] after the minor's admission).

Interview, on [redacted]/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 [redacted]/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 [redacted] on this day [redacted] had not been performing the task. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 365	Continued From page 13 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 [redacted] was under the impression the new Court Record Custodian had been trained to follow the "Daily Procedure" and [redacted] had not been monitoring this process. The Director reported [redacted] had not received any complaints from the Residents' attorneys regarding late notification. NC00121541	V 365		

"Attachment B"

LAST NAME	FIRST NAME	# OF DAYS REQUESTING
Court Scheduled for	2016	
[redacted]		

Date Revied	Reviewed By	DOCR. Review date
		/2016-MY
/2016	T. Carnes	/2016-MY
/2016	T. Carnes	/2016-MY
/2016	T. Carnes	/2016-MY
/2016	T. Carnes	/2016-MY
/2016	T. Carnes	/2016-MY
/2016	T. Carnes	/2016-MY
/2016	T. Carnes	/2016-MY
/2016	T. Carnes	/2016-MY
/2016	T. Carnes	/2016-MY
/2016	T. Carnes	/2016-MY
		/2016-MY
		014-MY
/2016	T. Carnes	014-MY
/2016	T. Carnes	014-MY
/2016	T. Carnes	014-MY
/2016	T. Carnes	014-MY
/2016	T. Carnes	014-MY
/2016	T. Carnes	014-MY
/2016	T. Carnes	014-MY
/2016	T. Carnes	014-MY
/2016	T. Carnes	014-MY
		016-MY
		016-MY
/2016	T. Carnes	016-MY
/2016	T. Carnes	016-MY
/2016	T. Carnes	/2016-MY
		/2016-MY
		/2016-MY
/2016	T. Carnes	/2016-MY
/2016	T. Carnes	/2016-MY

[redacted]	/2016	T. Carnes	[redacted]/2016-MY
	/2016	T. Carnes	/2016-MY
	/2016	T. Carnes	/2016-MY
	/2016	T. Carnes	/2016-MY
	/2016	T. Carnes	/2016-MY
			/2016-MY
			/2016-MY
	/2016	T. Carnes	/2016-MY
	/2016	T. Carnes	/2016-MY
	/2016	T. Carnes	/2016-MY
	/2016	T. Carnes	/2016-MY
	/2016	T. Carnes	/2016-MY
	/2016	T. Carnes	/2016-MY
	/2016	T. Carnes	/2016-MY
	/2016	T. Carnes	/2016-MY
			/2016-MY
			[redacted]/2016-MY
			/2016-MY
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			/2016-MY
			/2016-MY

		[redacted]		Consent
				Consent
				Consent
				Consent
				Consent
[redacted]				
Ammended				Consent
				Contest
DC				DC
				Contest
				Consent
DC				DC
				Contest
DC				DC
[redacted]				
Dismissed due to miscommunication				
Motion to continue				

SUBMIT REQ FOR REHEARING	THERAPIST	ATTEND COURT
[redacted]		
	[redacted]	DC
		Yes
		Yes
		Yes
		Yes
		Yes
		Yes
		Continued
		Continued
		Yes
[redacted]		
		Continued
Review - DC 10/27		DC
		Yes
		Yes
		Yes
Continued from 10/25		Yes
Continued from 10/25		Yes
		Continued
		Yes
[redacted]		
DC		DC
Continued from 11/1		Continued
Continued from 11/1		Yes
[redacted]		
DC 10/12		DC
		Consent

"Attachment A"

DATE	TIME	CALLED (NAME)	TALKED TO:	REASON FOR CALL/Communication (ADMIT, DISCHARGE, COMING TO COURT, ETC..)	SBC-C Employee Name
[redacted]	ex 5:15pm-ex	Corp Comp-ex	Miriam-ex	[redacted]	M.Yates
	/2016 10:34 AM	Clerk of Courts	VM		T. Carnes
	/2016 2:26 AM	Clerk of Courts	VM		M. Small
	/2016 12:00 AM	Clerk of Courts	VM		K.Sandidge
	/2016 10:34 AM	Clerk of Courts	VM		T. Carnes
	/2016 10:21 AM	Clerk of Courts	Julie Bailey		T. Carnes
	/2016 9:45 AM	Clerk of Courts	VM		T. Carnes
	/2016 9:27 AM	Clerk of Courts	VM		T. Carnes
	/2016 9:40 AM	Clerk of Courts	VM		T. Carnes
	/2016 3:56 PM	Clerk of Courts	VM		T. Carnes
	/2016 9:25 AM	Clerk of Courts	VM		T. Carnes
	/2016 8:38 AM	Clerk of Courts	VM		T. Carnes
	12:40 PM /2016	Clerk of Courts	VM		T. Carnes
	/2016 9:54 AM	Clerk of Courts	Julie Bailey		T. Carnes
	/2016 3:35PM	Clerk of Courts	VM		M. Yates
	/2016 9:53 PM	Clerk of Courts	VM		M. Small
	/2016 4:31 AM	Clerk of Courts	VM		A. Greene
	/2016 9:10 AM	Clerk of Courts	VM		T. Carnes
	/2016 8:27 AM	Clerk of Courts	VM		T. Carnes
	/2016 8:41 AM	Clerk of Courts	VM		T. Carnes
	/2016 1:43 PM	Clerk of Courts	VM		T. Carnes
	/2016 8:57 AM	Clerk of Courts	VM		T. Carnes
	/2016 9:25 AM	Clerk of Courts	VM		T. Carnes
	/2016 3:59 PM	Clerk of Courts	VM		K. Sandidge
	/2016 11:02 AM	Clerk of Courts	VM		T. Carnes
	/2016 10:09 AM	Clerk of Courts	Julie Bailey		T. Carnes
	/2016 1:15 PM	Clerk of Courts	VM		L.Ramey
	/2016 7:35 PM	Clerk of Courts	VM		M. Small

[redacted]	2016	10:43 AM	Clerk of Courts		T. Carnes
	2016	10:15 AM	Clerk of Courts	Julie Bailey	T. Carnes
	2016	9:05 AM	Clerk of Courts	Julie Bailey	T. Carnes
	2016	11:10 AM	Clerk of Courts	VM	T. Carnes
	2016	8:57 AM	Clerk of Courts	VM	T. Carnes

Reviewed Date	Reviewed By
[redacted]	2016 M.Yates
	2016 M.Yates
	2016 M.Yates
	2016 M.Yates
	2016 M.Yates
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	2014 M.Yates
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	2016 M.Yates
	2016 M.Yates
	2016 M.Yates

[redacted]/2016 M.Yates
[redacted]/2016 M.Yates
[redacted]/2016 M.Yates
[redacted]/2016 M.Yates
[redacted].2016 M.Yates

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RGLM12

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 9429360113

1. MEDICARE/MEDICAID PROVIDER NO. (L1)

2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **STRATEGIC BEHAVIORAL CENTER-CHARLOTTE**
(L4) **1715 SHARON ROAD WEST**
(L5) **CHARLOTTE, NC** (L6) **28210**

4. TYPE OF ACTION: 7 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: 1 (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 06 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___2. Technical Personnel
___3. 24 Hour RN
___4. 7-Day RN (Rural SNF)
___5. Life Safety Code
___6. Scope of Services Limit
___7. Medical Director
___8. Patient Room Size
___9. Beds/Room

* Code: A* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): YES (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
A follow up licensure investigation was conducted January 31, 2017 through February 2, 2017. A deficiency was found under NCAC 27G .1902 (b) Staffing.

17. SURVEYOR SIGNATURE [redacted] Date: 02/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL0601258 Y1	A. Building B. Wing Y2	2/3/2017 Y3

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0365 Reg. # G.S. 122C-224 LSC	Correction Completed 02/03/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR [redacted]	DATE 2/27/17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/27/2016	☒ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☒ YES ☐ NO			