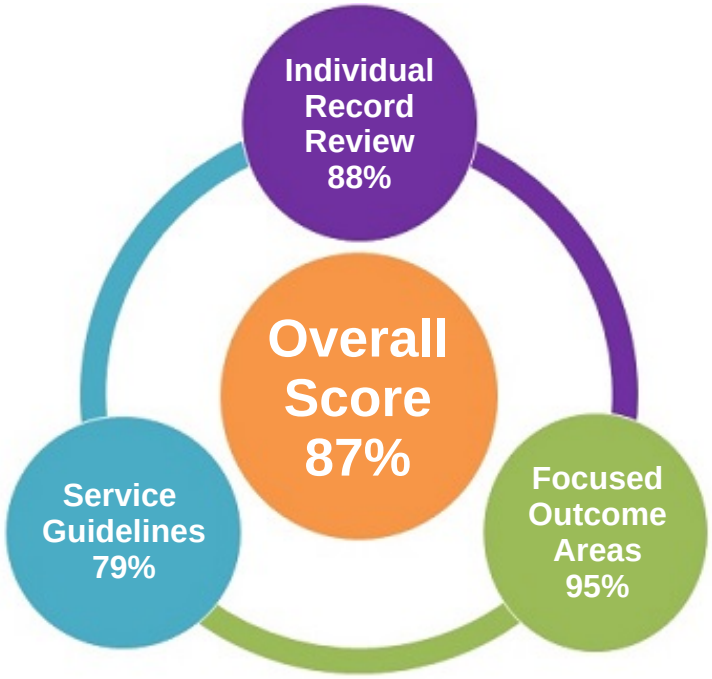
The Georgia Collaborative ASO

GAC000556

River Edge Behavioral Health

Crisis Stabilization Unit Quality Review Final Assessment		
Address: **3575 Fulton Mill Rd. Macon, Ga. 31217**		
Assessors: **Paula Perdue, RN; Shelley Greneker, LMFT; Jodi Rodriguez, LCSW; Nicole Griep, MSW, CPS-P**		
Review Date Range: **12/8/2025 - 12/11/2025**	CSU Type: **Adult / Child & Adolescent**	CSU Beds: **46**
Individual Records Reviewed: **20**	Temp Obs Beds: **9**	Transitional Beds: **0**
Staff Records Reviewed: **5**	Current Review Frequency: **Annual**	

The Georgia Collaborative ASO, in partnership with the Department of Behavioral Health and Developmental Disabilities (DBHDD), believes in accessible, high-quality care that leads to a life of recovery and independence. The provider should note any recommendations as an opportunity for quality improvement activities. The review is intended to measure the quality of your organization's systems and practices in adherence to DBHDD policies and standards. The Overall Score is calculated by averaging the categories below.



	Overall Score	IRR	Service Guidelines	FOA
Review Date: 10/21/2024	86%	85%	79%	94%
Review Date: 02/13/2024	92%	87%	92%	96%
FY25 Statewide Average	89%	89%	82%	95%

Note: The FY25 Statewide Averages represent the mean of scores for all reviewed providers.

Summary of Significant Review Findings

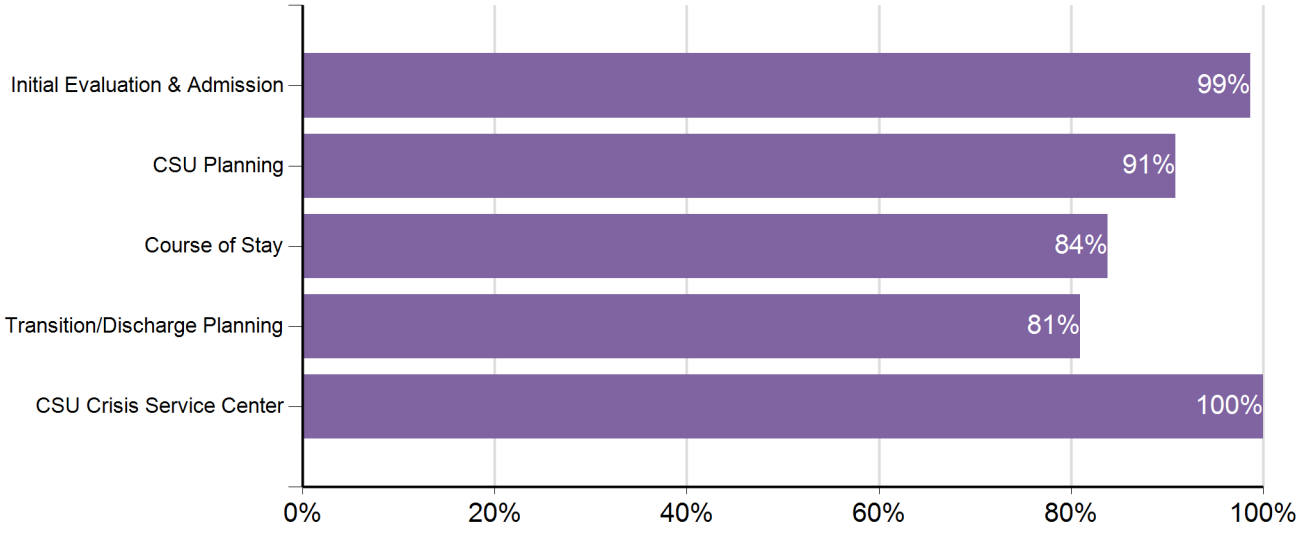
Strengths and Improvements:

- The treatment plan listed goals related to education on the benefits of whole health, such as healthy living and eating habits, which aid in mental/physical wellness and recovery.
- Safety crisis plans were completed at admission and reviewed/updated prior to discharge in ten adult records and five children and adolescent (C&A) records.
- Children and adolescent discharge summaries included a "Note to Caseworker" alerting aftercare providers to additional post discharge needs, i.e., "[individual] would benefit from a behavioral aide to offer additional assistance for the foster family. He would also benefit from a psychological evaluation to assess whether he has additional diagnoses or concerns for the foster family. Please note that the appointment above is with the local CSB because the foster mom wanted counseling within the school, but if his behaviors persist, then he would benefit from more intensive services such as IFI of Intensive Family Intervention."

Opportunities for Improvement:

- Treatment team was not held every 72 hours.
- The physician or physician extender must document the status of the individual daily.
- The Medication Administration Record (MAR) did not include all required criteria in five records.
- Documentation must include consideration of psychiatric medications, the individual's ability to access and afford medication post-discharge, how the medication will be obtained after the five-day post-discharge supply is exhausted, and how any associated lab work will be accessed and funded.
- Documentation did not support that Crisis Stabilization Unit (CSU) staff collaborated with the aftercare provider, when applicable.
- Medication consent forms were missing or did not contain all medications ordered.

Individual Record Review



The individual category scores are an average of questions within the category and are for the agency's reference only.

Individual Record Review: 88%				*Indicators scoring below 80%*
CSU Planning - 91%	**Yes**	**No**	**NA**	**%**
Plan of Care discussed every 72 hours.	10	5	0	67%
Course of Stay - 84%	**Yes**	**No**	**NA**	**%**
Individual has a MAR with all required criteria.	10	5	0	67%
The physician or physician extender documents the status of the individual daily.	11	4	0	73%
Transition/Discharge Planning - 81%	**Yes**	**No**	**NA**	**%**

There is documentation of consideration of psychiatric medications, the individual's ability to access and afford medication post-discharge, how the medication will be obtained after seven-day supply is exhausted, and how any associated lab work will be accessed and funded.	4	9	2	31%
A discharge summary was entered into the ASO's ProviderConnect/ batch system within the required time following the individual's discharge.	9	4	2	69%
Individuals who are identified as homeless, a Need of Supportive Housing (NSH) survey is completed and referral for necessary residential supports.	2	1	12	67%
High risk for suicide: Documentation supports that CSU staff have documented collaboration with the aftercare provider to include: Individual's safety plan, who will follow-up with individual and when it will occur, and that the individual's chart is flagged for high suicide risk upon discharge.	0	9	6	0%

Individual Record Review

Strengths and Improvements

The following were improvements from the prior Crisis Stabilization Unit Quality Review (CSUQR) on 10/21/24:

- All applicable records contained goals related to suicidal ideation on Individualized Recovery/Resiliency Plans (IRP). An overall improvement from 67%.
- Review of records demonstrated that all identified safety concerns were incorporated into the IRP. For example, one adult record documented placement on a detoxification protocol to address identified risk. This reflected an improvement from 50%.
- Documentation in all applicable records supported follow-up or attempted follow-up contact with the individual or guardian within five to seven days post-discharge, an overall improvement from 75%.

The Crisis Service Center (CSC) records scored 100% in the following areas:

- A Columbia-Suicide Severity Rating Scale (C-SSRS) was completed on all individuals at admission.
- Documentation of attempts to de-escalate the crisis were contained within the medical record, as needed.
- Documentation included a summary of findings and disposition of care for all five adult records reviewed.
- A crisis assessment was completed by a licensed clinician/medical staff within 24 hours.
- All orders were completed and signed within 24 hours. An improvement from 40%.

Opportunities for Growth

CSU Planning

- Treatment team was not held every 72 hours in two C&A records and three adult records. This is a recurring issue noted in the last two CSUQR, 02/2024 and 10/2024.
    - In one adult record, the minutes for the treatment team meeting held on 09/25/25 for an individual were blank.
    - In another adult record, documentation supported the individual met with the treatment team on the day of their admission; however, no other treatment teams were documented throughout their course of stay, which lasted seven days.
    - One adult record had no documentation of any treatment team meetings.
    - In one C&A record, the individual was admitted 10/03/25, with the first treatment team meeting dated 10/8/25.
    - One C&A record documented the course of stay 08/25/25 through 09/02/25. The record did not contain evidence that a treatment team meeting was held with the individual on 08/30/25.

Course of Stay

- The MARs lacked all required criteria in five records.
    - One adult record was missing a MAR.
    - In three C&A records, the MAR was missing the nurse's signature and credential in the legend as required.
    - One adult record had two identified medications errors. See *Service Guidelines for details.*
- The physician or physician extender did not document the status of the individual daily within four of 11 adult records. This is a continued opportunity for improvement that was noted on the last two CSUQRs in 02/24 and 10/24. For example:
    - One individual was not seen by the physician or physician extender on four consecutive days i.e., 09/08/25, 09/09/25, 09/10/25 and 09/11/25, for an admission that began on 09/07/25 and discharged on 09/12/25.
    - Another individual was admitted on 09/16/25 and discharged on 09/24/25. Five consecutive days were missing physician or physician extender documentation of daily status from 09/18/25 through 09/23/25.

Transition/Discharge Planning

- Documentation of considerations of psychiatric medication, the individual's ability to access and afford medication post-discharge, how the medication will be obtained after a seven-day supply is exhausted, and how any associated lab work will be accessed and funded was not evident within nine of 15 applicable records.

- In four of nine records, (two adult and two C&A), a discharge summary was not entered into the ASOs Provider Connect/batch system within the required time following the individuals' discharge. For example, one C&A record documented the individual discharged on 10/08/25; however, the authorization was submitted eight days later on 10/17/25.
- A Need for Supportive Housing (NSH) survey was not completed for one individual who presented on admission as homeless.
- Documentation did not support that CSU staff collaborated with the aftercare provider include individual's safety plan, who will follow-up with the individual and when it will occur, and that the individual's chart was flagged for high suicide risk upon discharge in any of the two C&A and seven adult applicable records.

Focused Outcome Areas

Focused Outcome Areas: 95%				*Indicators scoring below 80%*
Safety - 87%	**Yes**	**No**	**NA**	**%**
There is documentation the individual (or legal representative, guardian/parent of a minor), has been educated on the risk/benefits of all medications prescribed and there is a signed consent form that correlates to each medication.	11	4	0	73%
Rights - 96%	**Yes**	**No**	**NA**	**%**
Releases of Information contain all required components.	5	2	8	71%

Focused Outcome Areas

Strengths and Improvements

The following were continued strengths from the prior CSUQR on 10/21/2024:

- Documentation supported individuals in both adult and C&A records were referred to Case Management and other health services when the need was indicated in 100% of records. Examples include one individual who was discharged to a long-term residential treatment program and another who was referred back to their private provider.
- Documentation continued to demonstrate individuals' preferences were followed when clinically appropriate. For example, one individual requested to be discharged, signed an against-medical-advice (AMA) form, and was subsequently discharged per the individual's request.
- All records contained the individual/guardian's signed formal acknowledgement of rights and responsibilities at the onset of services, supports, and treatment.
- All records evidenced that Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules were reviewed with the individual/guardian.

The following were improvements since the previous CSUQR on 10/21/2024:

- All applicable records supported that the IRP was reassessed based upon changes in individual needs, circumstances, and/or response to treatment.
- Documentation supported individuals were assisted with goals for specific environments where they wish to live, learn, work and /or socialize. The score has improved from 90% in the prior review (10/21/24) to 100%.

Opportunities for Growth

Safety

- Four adult records lacked documentation that the individual had been educated on the risk/benefits of all medications prescribed and there was a signed consent form that correlated to each medication. For example:
  - Three records did not contain the required medication consent form.
  - In one record, there was a medication consent form; however, two of the three prescribed medications were not listed.

Rights

- Two C&A records contained release of information forms that were signed, but otherwise blank. This is an ongoing issue from the prior CSUQR (10/21/24)

Service Guidelines

1	Adult CSU Staffing Requirements Met	No
2	The Crisis Service Center staffing requirements met.	Yes
3	C&A staff requirements met.	Yes
4	The CSU has policies and procedures for identifying and managing individuals at high risk of suicide or intentional self-harm.	Yes
5	Program offerings for the CSU is designed to meet the biopsychosocial stabilization needs of each individual, and a medical and clinical leadership team annually approves the therapeutic content of the program (group therapy/training, individual therapy/training, education support, etc.) This annual review is documented by signature and date of review and by participating leadership.	No
6	Adherence to Medication Notification Policy	No
7	Protocols for Handling Licit and Illicit Drugs present	Yes
8	Adherence to Safe Storage of Medication Policy	Yes
9	Infection Control Plan Adherence	Yes
10	Seclusion & Restraint Policy Adherence	Yes
11	Therapeutic Blood Level Monitoring	Yes
12	Physician Availability for 3.7-WM	Yes
13	All staff credentialing criteria are met.	Yes
14	Psychiatrist Available for Consultation	Yes

# Yes	# No	# NA	SCORE
11	3	0	79%

Service Guidelines: 79%

Strengths and Improvements

The following was an improvement from the prior CSUQR on 10/21/2024:

- All medication refrigerator temperature logs were within the temperature parameters of 36 degrees - 41 degrees Fahrenheit.

The following was a continued strength identified during this CSUQR:

- All five staff members' credentialing documentation contained all required standard training requirements (STRs).
- Daily quality control checks for the glucometer were consistently documented, as outlined in the agency's policy.
- The C&A staff requirements were met.

Opportunities for Growth

Adult CSU Staffing Requirements

- The Behavior Health Crisis Center (BHCC) did not have a certified peer specialist (CPS) scheduled seven days a week between the hours of 8:00am and 10:00pm for the months of September, October and November 2025.
    - No waiver was submitted for this review.
        - Per the DBHDD Provider Manual: "A CSU that functions as a component of a BHCC must employ a full-time peer specialist (MH, CPS-AD) during the hours of 8:00am to 10:00 pm seven (7) days per week."

The Crisis Service Center Staffing Requirements

- The BHCC did not have a fully licensed clinician on staff at all times for the months of September, October and November 2025. A waiver for a licensed clinician was approved by the Department of Behavioral Health and Developmental Disabilities (DBHDD) for the period of 08/01/24 to 02/01/25.
    - A subsequent waiver was submitted to the DBHDD to cover 02/01/25 through 03/01/25; however, at the time of the review the waiver was not yet approved.
    - As the provider has a pending waiver, this did not impact the Service Guideline score.
        - Per the DBHDD Provider Manual. "At a minimum, staff must include a fully licensed behavioral health clinician onsite at all times."

Program offerings

- The therapeutic content program for 2025 annual review of the therapeutic content did not contain the required signatures from both the medical leadership and clinical leadership teams.
    - DBHDD Policy Stat, CSU: Program Description, 01-329 A, 17, "Program offerings for the CSU are designed to meet the biopsychosocial stabilization needs of each individual, and the therapeutic content of the program (group therapy/training, individual therapy/training, education support, etc.) are annually approved by a medical and clinical leadership team. This annual review is documented by signature and date of review and by participating leadership.
    - Additionally, during the previous CSUQR, it was recommended the BHCC develop separate programmatic offerings for each unique population (one for the C&A population and one for adult). This continued to be a recommendation.

Adherence to Medication Notification Policy

- During this CSUQR, one adult record contained two medication errors. The policy and procedure for tracking and trending medication errors were not followed.
    - Phenobarbital 60 mcg was ordered twice daily to be administered on 08/19/2025 but was only given at 9:00am with no explanation as to why the 10:00pm dose was not administered.
    - Levothyroxine 50 mcg daily was ordered but was not administered on 8/19/25 with no explanation as to why the dose was not administered.
        - Per agency policy CSU-50, Reduction of Preventable Medication Errors: "2. All medication errors will be reported to the prescriber. 3. An Incident Report will be completed on all medication errors. The Incident Report will be submitted to the REBH Risk Manager and Pharmacist for review. 4. Medication errors will be discussed as part of the Recovery Center Quality Improvement Committee, REBH Risk Management meetings, Safety Committee, and Pharmacy and Therapeutics Committee in order to track and trend all medication errors."

Crisis Stabilization Unit Site Visit Observations

As part of the virtual tour of the CSC at Baldwin location (stand-alone CSC) assessors identified the following:

- The lobby was clean and brightly lit with natural light.
- The current census was zero at the time of the tour.
- The unit remained the same as the prior CSUQR 10/21/24 with four beds and four reclining chairs.
- Agency security will transport individuals to the Macon CSU location if needed.

During the tour of the CSC/BHCC Macon location assessors identified the following:

- The facility's interior and exterior displayed a modern, open layout complemented by attractive and well-maintained landscaping.
- A separate entrance available for involuntary admissions.
- Security staff are onsite 24 hours a day, enabling staff to assist with the transportation needs of the individuals. Three security personnel are available to support the CSC, C&A and Adult CSU.
- The census was zero at the time of the tour.
- The medication room was awaiting installation of a new medication dispensing system and was not operational at the time of the tour. Medications are available through the Adult CSU if needed.

During the tour of the Adult CSU assessors identified the following:

- The census at the time of the tour was 20 divided between the "green" and "blue" units.
- Both units share a dining area and courtyard but are scheduled at different times.
- Night lights were encased in bedroom walls low to the floor to avoid trips and falls.
- The access-controlled entrance door into the unit features a window that allows clear visibility into the unit before entering.
- Each unit "green" and "blue" house their own seclusion and restraint rooms.
- Both medication refrigerators had open vials of Purified Protein Derivative (PPD) that were labeled with the date opened. The vials were missing staff initials and expiration dates. Technical assistance was provided regarding the proper labeling requirements. Both refrigerators were within temperature range.
- All the medication rooms throughout the facility have access-controlled entry with a sliding window for safe medication pass.
- A nursing board with individual names and room numbers that was visible from the dining area was replaced with a folding marker board that swings open and closed and is no longer visible to others. This is a noted improvement from the prior CSUQR (10/21/24)

During the tour of the C&A unit assessors identified the following:

- Visitation was allowed seven days a week with daily scheduled visitation times.
- Census on the unit was five at the time of the tour.
- Classroom on site with a teacher scheduled Monday through Friday.
- A quiet/sensory room is available, and features a peaceful ocean scene painted on the wall: the light switch has been relocated to the exterior of the room to prevent individuals from manipulating the lighting.
- All the furniture was weighted, including beds, rocking chairs, and tables.
- A spacious outdoor game area with padded flooring and padded poles around the basketball goal is available for safe recreational use.
- Catered meals, transported in insulated carrying cases for both the adult and C&A units. A full kitchen is available to reheat trays or provide alternative meal options if the individual does not prefer the menu selections of the day. Special diets are communicated with the catering company.
- Room signage incorporated Braille on each door, securely attached to the wall.
- Emergency food and water are securely stored; however, boxes of emergency food were expired (dates of 06/2021, 08/2024, 11/2024). Several gallons of emergency water were expired also.

Additional Comments on Practices

Additional strengths and concerns beyond the general scope of the review were discovered by reviewers. Additional issues/practice concerns may have the potential to impact service delivery, quality of care, or may represent a risk to the provider.

- Overall, records in the sample contained a lack of documented discharge planning throughout the individual's course of stay. For some C&A records, there was a lack of documented discussions with the parents/guardians of next steps in treatment, needed aftercare resources, and safety in the home (when clinically necessary). For some adults, records lacked documentation of linkage to community resources, such as affordability of medications, residential alternatives to a shelter, etc. In general, documentation of case management/discharge planning activities were found upon admission and at discharge, but not throughout the course of stay.
- The provider utilizes Carelogic as their EMR. Assessors had difficulty locating documents due to inconsistency in filing within the EMR. For example, the physician/physician extender and nursing progress notes were located in five different places within the EMR. It is recommended the provider work with their EMR vendor and River Edge staff to consistently house documents. When an individual is admitted to the CSU or discharged to River Edge's outpatient services, all staff should be able to easily access/located documentation within the EMR to facilitate coordination of care.
- Documentation within Treatment Team meeting notes did include a thorough summary of the individual's current mental status; however, notes did not describe/identify plans for discharge, needed resources/aftercare, communication with family/caregivers, whether any changes to the treatment plan were needed, the individual's input regarding progress/whether they felt ready for discharge, etc. Additionally, several treatment team documents were blank.

Individual Interviews

Individual Interviews Conducted: 5

- Five individuals were interviewed during this review. All reported:
  - being offered options for support and services.
  - felt they were treated with respect and dignity by the staff.
  - they involved in the development of the IRP:
    - *"I didn't feel like my meds have been helpful and they listened to me, and we've worked together to figure out what has been best for me."*
  - they felt supported in moving toward their goals:
    - *"They got me into residential."*
    - *"They are helping me seek long term treatment and found me somewhere I can go."*
    - *"They have focused on helping me stay off drugs. They found me long term placement and treatment."*
- When asked, "What are some things this agency does exceptionally well?" The individuals shared:
  - *"They have helped me find meetings for when I get out of here. They have also been accommodating of my special diet."*
  - *"They look after people very well. I have seen them work with other people and be empathetic."*
  - *"They are supportive and helpful. They haven't told me no. The food has been good."*

Quality Improvement Requirements

Providers are reminded of the responsibility to maintain internal processes which ensure immediate and permanent corrective actions on issues identified during the quality review process. DBHDD may request corrective action plans (CAPs) as quality review findings warrant. Please refer to the comments documented in each section above for specific information pertaining to the requirements below.

Requirements: Current and Prior Review

Individual Record Review - CSU Planning

- Each individual's NCP/IRP must be discussed a minimum of once every 72 hours with the treatment team.

Individual Record Review - Course of Stay

- The physician or physician extender must document the status of the individual daily.

Individual Record Review - Transition/Discharge Planning

- Documentation must include consideration of psychiatric medications, the individual's ability to access and afford medication post-discharge, how the medication will be obtained after the five-day post-discharge supply is exhausted, and how any associated lab work will be accessed and funded.

Focused Outcome Areas - Safety

- Individuals (or parent/guardian for youth) must be educated on the risks and benefits of all prescribed medications.

Focused Outcome Areas - Rights

- Releases of information must contain all required components.

Compliance w/Service Guidelines - Crisis Stabilization Services

- The adult Crisis Stabilization Unit must meet all staffing requirements.
- The provider must adhere its policy which defines the requirements and procedures for timely notification to the prescribing professional regarding drug reactions, medication problems, medication errors, and refusal of medications.

Requirements: Current Review

Individual Record Review - Transition/Discharge Planning

- Discharge summaries must be entered into the ASO's ProviderConnect/batch system within 48 hours of discharge.
- A Need of Supportive Housing (NSH) survey should be completed, and a referral made, for necessary residential supports for all individuals identified as homeless.
- CSU staff must collaborate care with the aftercare provider.

Compliance w/Service Guidelines - Crisis Stabilization Services

- Program offerings for the CSU must be designed to meet the biopsychosocial stabilization needs of each individual and a medical and clinical leadership team must annually approve the therapeutic content of the program (group therapy/training, individual therapy/training, education support, etc.) This annual review must be documented and signed by participating leadership and dated.

Providers have the opportunity to appeal review findings for up to ten (10) business days following notification that their written Final Assessment has been saved to the Collaborative's website. For appeals procedures and submission requirements, access the Georgia Collaborative's website to review the appeals process in the Quality Management section of the Provider Handbook and for a current version of the Review Appeal Form at this link: https://www.georgiacollaborative.com/providers/behavioral-health-providers/