STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-158	A. BUILDING: _____ B. WING _____	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS TREATMENT FACILITY	769 ABERDEEN ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and annual survey was completed on 10/23/18. Deficiencies were cited. Unsubstantiated complaints were: #NC00139183; #NC00139288 and NC00143898. Substantiated complaints were: #NC00139355; #NC00140702; #NC00140723; #NC00141610; #NC00141736; #NC00142136 and #NC00144301. This facility is licensed for the following service category: 10A NCAC 27G 1900 Psychiatric Residential Treatment for Children and Adolescents. The facility has two separate residential units. Each unit has a capacity for 12 clients: one unit for ages 6 - 12 and one unit for ages 13 -17.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) The facility shall meet requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills.	V 109		

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V 109	Continued From page 1 (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility management failed to assure the qualified professionals (Qualified Professional (QP #1) & Executive Director) demonstrated the knowledge, skills and abilities required. The findings are: Review on 8/14/18 of the facility's organizational chart revealed the Executive Director: - has primary management authority for the operation of the facility and services. - oversees all client services and facility's compliance with all functions related to client services. Review on 8/14/18 of QP #1 record revealed: - Hired date 4/27/17 - QP #1 for clients ages 6 - 12. Review on 5/24/18 of Former Client (FC) #1's record revealed: - Admission date of 5/3/18.	V 109		

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V 109	Continued From page 2 - Age = 9 - Diagnoses of Intermittent Explosive Disorder; Oppositional Defiant Disorder with Anxious Distress; Sensory Processing Disorder and History of Head Injury. - Removed from facility (discharged) on 5/19/18 at request of parent after 17 days. Interview on 5/25/18 with FC #1's parent revealed: - QP #1 and Executive Director (ED) did not maintain communication and contact with her about FC #1's medical treatment and staff interventions to keep him safe. Examples are: 1. She was not included in the service planning meetings or the facility's implementation of FC #1's treatment. 2. The QP #1 did not direct staff to notify her of any injuries FC #1 received, regardless of level. She also requested weekly contact about FC #1's behavior. 3. FC #1 had bruises and abrasions beginning his first week and QP #1 nor ED notified her when he was injured. 4. QP #1 and ED could not clarify the circumstances under which FC #1 was injured. 5. She received conflicting information from FC #1, staff and the QP #1 about a large bruise she saw on the client's arm during a visit on 5/12/18. 6. She asked QP #1 to conduct a formal investigation into circumstances surrounding the injury as she felt the explanations offered were conflicting and "did not make sense." 7. QP #1 said he would request the facility's doctor to call her when came to the facility on 5/18/18. However, facility's physician did not see FC #1 and QP #1 nor any staff contacted her with information. 9. FC #1 alleged staff caused some of his injuries. However, QP #1 and ED could not	V 109		

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V 109	Continued From page 3	V 109		

provide any clarity nor documentation they investigated the client's allegations.
10. She never received more than two phone calls from the facility QP #1, ED or nurse. The second call was on FC #1's 17th day in facility to cancel the scheduled visit with FC #1 on 5/19/18.
- QP #1 and ED said they could "handle him" then tried to prevent her from discharging her son.
- QP #1 said she "could not just come and remove him" from the facility. However, she discharged FC #1 on 5/19/18 and took him to a hospital.
- She did not have any further contact from QP #1 or ED and has not received the requested records.

Interviews on 5/24/18, 6/14/18 and 7/10/18 with local police and local Department of Social Services (DSS) Child Protection Services (CPS) staff revealed:
- Police and CPS staff conducted investigations into allegations of physical and verbal abuse a client made against staff at the facility.
- The QP #1 was one of the staff accused of physically and verbally abusing the client.
- QP #1 and ED were resistant and uncooperative with their efforts to speak with clients and staff for the investigation. They refused to allow them to meet with a client who alleged he was sexually molested by another client.

During interview with QP #1 on 6/15/18:
- Surveyor requested documentation of internal investigation into above allegations and actions taken by facility to protect other clients during the internal investigation.
- QP #1 denied he was aware of any allegation against him.
- Conducts groups however, he "rarely" works directly with the clients.

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V 109	Continued From page 4 - He reported he and ED had conducted an internal investigation into the allegation Staff #1 pushed FC #1 into his bed, however QP #1 and ED were unable to provide documentation of the investigation. Review on 7/9/18 of Client #2's record revealed: - Admission date of 6/23/18. - Age = 11 - Attention Deficit Hyperactivity Disorder (ADHD;) Oppositional Defiant Disorder (ODD;) Bipolar Disorder; Asthma; History of Sexual Abuse (Victim) Interview on 7/6/18 with Client #2 revealed: - QP #1 and ED moved him in March 2018 from unit with clients ages 6 - 12 to unit with clients ages 13 - 17. - "They did it (moved him to unit with older kids) for punishment. I was fighting younger kids." Review on 7/12/18 of information provided by a Former Staff confirmed: - She worked in the unit with clients age 6 - 12 until June 2018. - QP #1 and ED instructed staff to move Client #2 from unit with clients age 6 - 12 to unit with clients age 13 - 17. The client was fighting younger clients and physically larger than the clients age 6 - 12. - Staff informed QP #1 and ED of Client #2's acts of sexual self-gratification "for the benefit" of an older client in the room near his however, they did not move the client to another room. - Another client was "forced" to remain in a room with a client (now discharged) who bullied him and "gave him a black eye." - ED allows staff to be "habitual for intentionally placing bullies" in the same room with the clients they bullied.	V 109		

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V 109	Continued From page 5 Review on 8/14/18 of Client #6's record revealed: - Age = 15 - Admission date of 1/18/18 - Diagnoses of ADHD; ODD and Bipolar Disorder Interview on 7/26/18 with another Former Staff revealed: - He was employed through July 2018 and worked with clients age 6 - 12 and clients age 13 - 17. - A staff on unit with clients age 13 - 17 was suspected of smoking marijuana in his car in the facility parking lot prior to checking in for work. - An odor of marijuana was on the staff and his clothing. After he apologized, QP #1 permitted the staff to go work on unit with the clients age 13 -17. - QP #1 threaten Client #6 in front of other clients. He said the client would be put in jail for sexual assault. The client was engaging in sexual self-stimulation in front of other clients. Review on 8/16/18 of Client #12's record revealed: - Admission date of 4/24/18 - Age = 6 years - Diagnoses of ADHD; ODD and Disruptive Mood Dysregulation Disorder Interview on 8/16/18 with Client #12's Case Manager revealed: - QP #1 did not inform her regarding the circumstances surrounding the restraint of the client when the restraint occurred. - Client reportedly was restrained on 7/21/18 after he hit, kicked and bit staff. - The information was not provided until 7/23/18 at Child and Family Team Meeting. - QP #1 said a report was submitted to IRIS and	V 109		

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V 109	Continued From page 6 available to the local management entity. - However, as of 7/24/18, the incident was not on IRIS. - She requested the facility's documentation however, QP #1 said the facility does not document incidents and/or behaviors in the facility's system if the incident was reported to IRIS. Review on 8/9/18 of FC #4's record revealed: - Admission date of 7/3/17. Discharge on 6/15/18 - Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder; Conduct Disorder; Persistent Mood Disorder and Cannabis Use Disorder - Guardian was FC#4's home county Department of Social Services (DSS) Interview on 8/17/18 with FC #4's Care Coordinator and DSS Social Work Guardian revealed: - ED and QP #1 did not work with them to assure a smooth transition/discharge to a lower level of care for FC #4. - FC #4 missed one week of school because QP #1 never responded to the request for the proper documentation. (See Tag V317 for more details) This deficiency is cross referenced into 10A NCAC 27G .1901 SCOPE (V314) for a Type A-1 rule violation and must be corrected within 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS	V 110		

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V 110	Continued From page 7 (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility management failed to assure 9 of 20 audited paraprofessional staff (Lead Staff #1; Shift Lead #2; Staff's #2; #3; #4; #5; #6; #7 & #8) demonstrated the knowledge, skills and abilities required by the population served. The findings are:	V 110		

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V 110	Continued From page 8 Review on 5/30/18 of Lead Staff 1's personnel file revealed: - Hire date of 3/18/18 - Works as Lead Staff with clients ages 6 - 12 Review on 8/14/18 of Shift Lead #2's personnel file revealed: - Hire date of 5/31/17 - Currently works as Shift Lead for clients ages 13 - 17 Review on 8/21/18 of Staff #2's personnel record revealed: Hire date of 8/16/18 Review on 8/14/18 of Staff #3's personnel file revealed: - Hire date of 8/28/17 - Currently works as direct care staff on 2nd shift - Side B (ages 6 - 12) - Recently moved from work with clients on Side A Review on 8/14/18 of Staff #4's personnel file revealed: - Hire date of 11/15/17 - Currently works as direct care staff on 2nd shift - Side B (ages 6 - 12) Review on 5/30/18 of Staff #5's personnel file revealed: - Initially hired on 1/3/17 as direct care staff. - Also worked as Senior Team Leader on Side B (ages 6 - 12) Review on 8/14/18 of Staff #6's personnel file revealed: - Hire date of 11/10/17 - Works as direct care staff on 2nd shift - Side A	V 110		

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V 110	Continued From page 9 (13 - 17) and Side B (ages 6 - 12) Review on 8/14/18 of Staff #7's personnel file revealed: - Hire date of 1/8/18 - Works as direct care staff on Side A (ages 13 - 17) Review on 8/14/18 of Staff #8's personnel file revealed: - Hire date of 3/8/18 - Works as direct care staff on 2nd shift - Side A (13 - 17) During the survey from 7/9/18 - 8/16/18, facility nurses reported witnessing the following: - "Staff go toe to toe with the kids" - argue and use vulgarities. - Staff "slap them up and slap them around - on the butt and bottom." When informed this type of interaction with clients is not appropriate, staff say they are just "playing." - Client #6 reported to nurse staff, specifically Staff #6, has "done stuff to us" then say they were just kidding. - A nurse intervened to stop Staff #6 during an incident when she witnessed him "choking a kid." During interviews during the survey from 7/9/18 to 8/16/18 clients reported: 1. staff intentionally try to cause clients pain during restraints 2. staff engage in verbal harassment and putdowns: examples are: a. an 8 year old said staff "beat on the boys." b. a 13 year old reported Staff #8 called him a "cry baby," because he is "whining all the time;" c. Staff "Curse at us - call people the 'B' word" Specific examples of staff verbal harassment and	V 110		

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V 110	Continued From page 10 putdowns follows: 1. Interview on 5/25/18 with FC #1 said: - Staff allowed other clients to tease him and call him names (fat, stupid) and staff laughed. - Staff allowed other clients to hit him and beat him before they did anything to stop the fights. - He felt staff did not like him and supported the other clients. - Staff would stand in the doorway of his room and block him from getting out. He would get "in staff's face" and verbally and physically attack them. He said "I would cuss them out." - He said "They (staff) couldn't control the clients." 2. During interview on 7/6/18, Client #2 said staff tried to make him feel bad about himself. He said: - Staff asked him "Do you prefer men or women?" - "Staff call people names. They called me a faggot.'" Client said "That's a bundle of sticks. But they really mean gay" - Staff #3 told him "The reason you in here now, your family don't want you." - Staff had a rap battle. In the rap, the staff made fun of him - example: "[Client #2] is a dirty rat. Ain't no fun in that." (See Tags V367 & V513 for more details on competency of paraprofessional staff) This deficiency is cross referenced into 10A NCAC 27G .1901 SCOPE (V314) for a Type A-1 rule violation and must be corrected within 23 days.	V 110		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that:	V 115		

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V 115	Continued From page 11 (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children. This Rule is not met as evidenced by: Based on interviews and record reviews, facility staff failed to prepare meals that met the nutritional needs of clients. The findings are: Interviews with the facility's Registered Nurses during the survey 7/9/18 -8/16/18 revealed the following concerns related to food: - Client's reported: a. Food is the same every week and they are not getting enough to eat. - examples: "Taco Tuesdays" (2 tacos;) Friday - pizza; 4 fish sticks	V 115		

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V 115	Continued From page 12	V 115		

and bag of chips for lunch; 1 Hot pocket or 1 corn dog for lunch; 6 chicken nuggets and fries for dinner
b. Seconds, when available, are very small.

Interview on 7/26/18 with clients revealed:
- A client in the unit for age 13 - 17 wrote a "petition" to request better food with more choices and an increased amount. He said "It's not enough food. They give us like a quarter of an apple for a snack."
- All the clients in the unit signed the petition.
- Clients were temporarily "punished" and were given even less food after they gave the petition to staff.
- He said the nurse told him the facility gives clients "a little bit of food" because they do not need to eat a lot. "Your stomach will shrink and then you will not be hungry.

During additional interviews on 8/14/18, nurses reported:
- Some clients may not be receiving a sufficient amount of food to maintain proper growth and development.
- They are concerned because the person responsible for purchasing food for the facility recently said the food budget must be reduced.
- Clients said they lost weight and only one client has a physician's recommendation to lose weight.
- Nurses check of client weights each week seem to support some client's complaints about weight loss.

Review on 8/16/18 of client weights documented by the facility nurse revealed the following examples of weight loss:
- Age = 17; admission 11/22/17 weight = 278.6 lbs; on 4/29/18 = 268 lbs
- Age = 15; admission 1/18/18 weight = 161.8 lbs;

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V 115	Continued From page 13 on 8/11/18 = 131 lbs - Age = 14; admission 3/12/18 weight = 157.9 lbs; on 8/11/18 =145 lbs - Age = 12; admission 3/12/18 weight = 105 lbs; on 8/11/18 = 99 lbs - Age = 13; admission 3/22/18 weight = 91 lbs; on 8/5/18 = 86 lbs - Age = 16; admission 3/26/18 weight = 129 lbs; on 8/11/18 = 122 lbs - Age = 16; admission 4/19/18 weight = 151.5 lbs; on 8/11/18 = 149 lbs - Age = 14; admission 6/15/18 weight = 105 lbs; on 8/11/18 = 99 lbs	V 115		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug;	V 118		

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V 118	Continued From page 14 (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to assure: (a) physician's order was available for medications being administered and medication was available to be administered as ordered by a physician for 1 of 18 audited current client's (#3;) and (b) failed to follow physician's orders for 2 of 18 audited current clients (#3 & #6) The findings are: Review on 7/9/18 of Client #3's chart revealed: - Admission date 1/29/18 - Age = 9 - Diagnoses of Bipolar Disorder - Unspecified Type; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder (ADHD) - Unspecified Type Additional review on 8/16/18 of Client #3's chart revealed: - May 2018 thru July 2018 MAR's documented the client was administered Chlorpromazine (Thorazine) 100mg, two tablets 3 times daily. - August 2018 MAR with documentation the Chlorpromazine 100mg was not available to be administered to the client on 8/13; 8/14; 8/15 and 8/16. - No order was found for the client to be	V 118		

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V 118	Continued From page 15	V 118		

administered the medication.
- A note from the pharmacy dated 8/15/18 documented the nurse requested a refill of the client's Chlorpromazine. However, the medication could not be refilled because the refill required "a safety documentation prior to authorization through Medicaid. Please have prescriber [facility doctor's name] contact Medicaid at their earliest convenience to provide the proper information for the authorization."

Interview on 8/16/18 with the facility nurse revealed:
- They attempted to contact the facility physician before Client #3's medication ran out, however they had difficulty contacting him.
- The facility physician was aware of the need to submit a prior authorization for Client #3's Chlorpromazine. During his last visit to the facility on 7/29/18, he obtained the forms and indicated he would submit the request. However he had not yet completed the forms for prior authorization of the client's medication.
- The facility physician ordered the medication, however they did not have a current order nor the medication therefore the client was not being administered the medication.

Review on 8/16/18 of Client #6's chart revealed:
- Admission date of 1/18/18
- Age = 15
- Diagnoses of ADHD, Oppositional Defiant Disorder, Bipolar Disorder
- Physician's orders for: 6/21/18 - Divalproex ER 500mg, Two tablets at bedtime and Divalproex ER 250mg - One at bedtime.
- August 2018 MAR documenting the client was administered the Divalproex ER 250mg "One every morning."
- Report dated 6/21/18 of check of Valproic Acid

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V 118	Continued From page 16 documented it was at a "Toxic Level." - Physician dated reviewed report on 6/26/18 and ordered staff to recheck level. - No recheck of Valproic Acid Level was found in the client's record. During interview on 8/16/18 the facility nurse reported: - Blood tests are sent to an outside laboratory. - She was unable to clarify why the follow up retest the doctor ordered to check Client #6's Valproic Acid Level was not documented. This deficiency is cross referenced into 10A NCAC 27G .1901 SCOPE (V314) for a Type A-1 rule violation and must be corrected within 23 days.	V 118		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.	V 132		

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V 132	Continued From page 17 c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all allegations of abuse against 4 of 20 audited staff (Staffs #1, #9 & #10; Lead Staff #1) and 1 of 1 Qualified Professional (QP #1) including injuries of unknown source affecting 2 of 18 audited current clients (#9 & #11) and 1 of 2 audited former clients (FC #1;) The findings are: Review on 5/30/18 of Staff #1's personnel file revealed: - Hire date of 3/8/18 - Works as direct care staff for clients ages 6 - 12) and as facility cook.	V 132		

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V 132	Continued From page 18 Review on 5/30/18 of Staff 9's personnel file revealed: - Hire date of 2/4/17 - Works as residential staff for clients ages 13 - 17 Review on 5/30/18 of 10's personnel file revealed: - Hire date of 7/13/16 - Works as direct care staff on 3rd shift for clients ages 13 - 17 Review on 5/30/18 of Lead Staff #1's personnel file revealed: - Hire date of 3/18/18 - Works as Lead Staff for for clients ages 6 - 12 Review on 8/14/18 of QP #1 record revealed: - Hired date 4/27/17 - QP #1 for clients ages 6 - 12 1. Review on 5/24/18 of Former Client (FC) #1's record revealed: - Admission date of 5/3/18. - Age = 9 - Diagnoses of Intermittent Explosive Disorder; Oppositional Defiant Disorder (ODD) with Anxious Distress; Sensory Processing Disorder and History of Head Injury. - Removed from facility (discharged) on 5/19/18 at request of parent after 17 days. Interview on 5/25/18 with FC #1's parent revealed: - During the 17 days FC #1 was in the facility, he sustained bruises and abrasions beginning the first week. - By discharge, he had multiple injuries - bites, bruises, and scratch marks on hand, face, neck, abdomen, back and arms.	V 132		

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V 132	Continued From page 19 - He told her the injuries came from staff and fights with clients. - Staff informed her the injuries were self inflicted and/or caused when he attacked other clients. - However, she was never informed of the injuries. - On 5/12/18 she visited FC #1 and he had "a very large bruise and abrasion on his arm." - On 5/13/18 she visited FC#1 again and he alleged Staff #1 pushed him into his bed and caused the injuries. - On 5/14/18 she informed the Qualified Professional (QP#1) of the allegation and requested the facility conduct a formal investigation. - QP #1 said he and the Executive Director (ED) conducted an investigation and determined the client injured himself during an "outburst." - On 5/19/18 she visited FC #1 and found "red/purple marks on his left side of his neck" and "marks/scratches throughout his entire left upper shoulder/chest area." She said [FC #1] "was very disheveled. He looked like he had been through a war zone. He didn't act normally." - Staff would not give an explanation of how FC #1 received the bruises. - FC #1 further alleged the Lead Staff #1 "spit in his own hand and smashed it all over (FC #1's) face, then kicked him in his private part calling him an ass-hole." - Both QP #1 and ED were present when FC #1 made the allegation. During interview on 5/30/18 FC #1's parent provided various pictures of the client's bruises. Pictures were dated 5/19/18. Review of the pictures revealed: 1 - red abrasions, scratches and bruises on his left side/abdomen 2 - scratches near the left shoulder and on the left	V 132		

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side of the head
3 - bruises around the base of the neck and on the left side below his ribs
4 - bite mark on the left hand

Review on 6/15/18 of FC #1's medical record revealed:
- The nurse was aware of one allegation against staff.
- She documented on 5/12/18, she examined a bruise on FC #1's left arm.
- Nurse's report also documented the client alleged staff caused the bruise then "changed his mind."

Interview on 6/24/18 with the local police revealed:
- Police and investigator from local Department of Social Services (DSS) Child Protection Services (CPS) Unit investigated the allegations of physical and verbal abuse FC #1 made against staff at the facility.
- Police informed facility management a client made the following allegations: 1) Staff #1 pushed him into his bed and he hit his arm on the metal frame causing the bruise; 2) QP #1 grabbed him by his shoulder and led him around calling him a "doggy" while staff and other clients laughed; 3) Lead Staff #1 spit in his hand and rubbed it in his face, then kicked him in his groin.

During interview with QP #1 on 7/9/18:
- Surveyor requested documentation of internal investigation into above allegations and actions taken by facility to protect other clients during the internal investigation.
- QP #1 denied he was aware of any allegation against him.
- He reported he and ED had conducted an internal investigation into the allegation Staff #1

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pushed FC #1 into his bed.
- However QP #1 and ED were unable to provide documentation of the report or of an internal investigation.

During additional interview on 7/9/18 with management staff:
- ED provided a copy of a letter dated 5/25/18.
- Letter documented the facility: a) conducted an internal investigation "into allegations against the facility and [Lead Staff #1]" and b) determined "there were no findings of fault found on behalf of Canyon Hills Treatment Facility and/or any staff of Canyon Hills Treatment Facility."
- Accused staff continued to work during the internal investigation.

Review on 8/14/18 of Client #9's chart revealed:
- Admission date of 5/29/18
- Age = 7
- Diagnoses of Attention Deficit Disorder (ADHD;) ODD; Conduct Disorder; Mood Disorder and Disruptive Behavior Disorder.

Interview on 8/14/18 with a nurse revealed:
- Client #9 reported to the nurse with signs of significant older bruising on both sides of his abdomen.
- The client said he received the bruises when staff restrained him approximately one week ago.
- He reported Lead Staff #1 "put him on the wall" to restrain him.
- Nurses were not called for authorization and were not present during the restraint.
- Nurse who examined the client was not involved in the restraint and thus did not document the restraint.
- The nurse was not aware if the incident was reported to HCPR.

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V 132	Continued From page 22 Review on 8/14/18 of Client #11's chart revealed: - Admission date of 11/22/17 - Age = 17 - Diagnoses of ODD and Conduct Disorder - Childhood Onset. Review on 8/14/18 of the "Restrictive Intervention Order/Follow-up Forms" revealed: - An incident report dated 12/8/17 documenting Client #11 reported to the nurse with bruises after a restraint. - "Consumer reported to nurse and RA (residential assistant) that he had a bruise on his right upper thigh. Nurse inspected and found a large bruised area in different stages of healing. Bruising is noted on the front and lateral aspect of consumer's right upper thigh - red, blue and dark dusky bruising noted. Client reported "I got this bruise from the last time that I was restrained here, I don't remember when that was exactly, but it was about a week ago, I think." - Staff #9 and Staff #10 were identified as staff who did restraint. - No documentation was found of further investigation or report related to the client's allegation. Initial Review on 5/25/18 of the state incident reporting system revealed: - No report to the Department of a) FC #1's above allegations of staff abuse against Staff #1; Lead Staff #1 and QP #1 nor b) the facility's completed investigation of the alleged acts. - No documentation was available of efforts by the facility to protect residents from harm while they were in the process of the investigation they reported the facility conducted. Additional subsequent review on 7/9/18 and 8/16/18 of the state incident reporting system	V 132		

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V 132	Continued From page 23 revealed: 1. A report dated 6/7/18 documented FC #1's allegation of an incident on 5/19/18 against the Lead Staff #1. a) However, the 6/7/18 report did not initially contain all required information b) The facility submitted additional documentation of the 5/19/18 incident involving Lead Staff #1 on 6/21/18 - after HCPR requested additional clarification and information. 2. In addition to the above allegations, there was no report to the HCPR on the following allegations: a) Client #9's allegation against Lead Staff #1. b) Client #11's allegation Staff #9 and Staff #10 injured him during a restraint. 3. The above alleged acts were not reported and investigated within the required time frame. 4. It was not possible to determine if the facility made every effort to protect residents from harm while the incidents were investigated. This deficiency is cross referenced into 10A NCAC 27G .1901 SCOPE (V314) for a Type A-1 rule violation and must be corrected within 23 days.	V 132		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do	V 314		

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V 314	Continued From page 24 require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on record reviews, interviews and observation, the facility failed to meet the scope	V 314		

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V 314	Continued From page 25 of a psychiatric residential treatment facility (PRTF.) The findings are: Cross Reference: Tag V109 - 10A NCAC 27G. .0203 Competencies Of Qualified Professionals and Associate Professionals - Based on record reviews and interviews, the facility management failed to assure the qualified professionals (Qualified Professional (QP #1) & Executive Director) demonstrated the knowledge, skills and abilities required. Cross Reference: Tag V110 - 10A NCAC 27G. .0204 Competencies and Supervision of Paraprofessionals - Based on observations, interviews and record reviews, the facility management failed to assure 9 of 20 audited paraprofessional staff (Lead Staff #1; Shift Lead #2; Staff's #2; #3; #4; #5; #6; #7 & #8) demonstrated the knowledge, skills and abilities required by the population served. Cross Reference: Tag V118 - 10A NCAC 27 .0209 Medication Requirements - Based on record reviews and interviews, the facility staff failed to assure: (a) physician's order was available for medications being administered and medication was available to be administered as ordered by a physician for 1 of 18 audited current client's (#3;) and (b) failed to follow physician's orders for 2 of 18 audited current clients (#3 & #6.) Cross Reference: Tag V132 - G.S. §131E-256 Health Care Personnel Registry - Based on record reviews and interviews, the facility failed to report all allegations of abuse against 4 of 20 audited staff (Staffs #1, #9 & #10; Lead Staff #1) and 1 of 1 Qualified Professional (QP #1,) including injuries of unknown source affecting 2	V 314		

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V 314	Continued From page 26 of 18 audited current clients (#9 & #11) and 1 of 2 audited former clients (FC #1) Cross Reference: Tag V315 - 10A NCAC 27G. 1902 Staff - Based on record reviews, interviews and observation, the facility failed to: 1) employ a Medical Director who was a physician who was board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness and 2) assure at least two direct care staff members were present at all times with every six children or adolescents in each residential unit. Cross Reference: Tag V367 - 10A NCAC 27G .0604 Incident Reporting Requirements For Category A And B Providers = Based on record reviews and interviews, the facility failed to report all Level II incidents. Cross Reference: Tag V513 - 10A NCAC 27 .0101 Least Restrictive Alternative - Based on record reviews, interviews and observations, facility management failed to assure 8 of 20 audited staff (Lead Staff #1; Shift Lead #2; Staff's #2; #3; #4; #5; #6 & #7): a) used approved restrictive intervention methods; b) used the least restrictive and most appropriate intervention; c) used actions designed to insure dignity and respect during the intervention and d) used restrictive intervention as a last resort. A. The following are examples of concerns related to the facility's structured living environment; specialized interventions and therapeutic services 1. Interview on 7/26/18 with the Qualified Professional (QP) #1 revealed: - The facility does not have a Clinical Supervisor	V 314		

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V 314	Continued From page 27 for supervision of clinical staff and guidance of therapeutic interventions/services for clients in the facility. - The facility has not had a Clinical Supervisor for more than three months. - Currently, he is the only QP in the facility. - He is not aware of the "exact events" that occur in the client's units. He said "I am not on the floor. I seldom work directly with the kids." - He conducts group sessions for the 12 clients age 6 - 12. NOTE: A new QP was hired for the unit with clients age 13 - 17 by the end of the survey on 8/23/18. 2. Interview on 7/26/18 with the staff assigned to be the teacher revealed: - He was previously Qualified Professional (QP) for the unit with clients ages 13 - 17. - He began work as teacher in the facility the last half year after the former teacher left. - He has a degree in Art, not education, however has attended workshops in education. - He said "I do my own lesson plans - everything." - QP #1 does not work with clients or staff on the unit for ages 13 - 17. - Staff are responsible for developing and implementing interventions to address behaviors associated with the client's diagnosis. He said "He (QP #1) is more paperwork oriented." - He works with staff to help them set up ideas and activities to motivate the clients to improve their behavior - like "Consumer of the Week." 3. During interview on 8/14/18, the Lead Nurse reported: - The facility contracted two private Clinical Social Workers to provide therapy - one for each unit housing 12 clients each. - There has not been a Clinical Director to	V 314		

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V 314	Continued From page 28 supervise the therapist since the facility's Clinical Director resigned approximately six months ago. - The therapist are "trauma-focused" and expected to provide individual counseling as well as family counseling to all clients on a weekly basis. However, they do not see every client on a weekly basis. - Therapist have only provided individual sessions. They have not conducted groups. - The psychiatrist who provides Substance Abuse treatment for the clients is the "only consistent therapist." He tries to fill in for the therapist. - There is no documentation of therapy contacts in client records. Therapist maintain their own documentation.. 4. During the survey period from 7/9/18 - 8/16/18, facility RN's for all shifts reported the following during interviews regarding therapeutic services for clients: - "[Therapist (clients ages 13 - 17)] may not see all the kids on a regular schedule, only her favorites." - "[Therapist (clients ages 6 -12)] will see 7 out of the 12 on her side most of the time." - The clients often ask why they have not had a chance to meet with their therapist. - "All the kids could use more therapy. It should be twice a week." - "Lots of parents are upset because the kids have not been getting therapy." 5. Further interview on 8/14/18 with nurse's regarding the facility's living environment revealed: - Some clients are "bored" especially during summer months when the client day is "unstructured" - no regularly implemented structured schedule. - Staff expect the clients to sit in the community	V 314		

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room all day and "have no issues." "They tell them to sit down and watch TV"
- Staff do not always follow the facility's policy to call the nurses for authorization to restrain a client before and/or during a restraint.
- Some staff use restraints to "threaten" clients.
- Staff may engage in actions that create an environment of conflict for clients:
a. verbally push clients to "act out" so they have to be restrained
b. threaten them with jail
c. use demeaning names; i.e. "gay," cry-baby, pervert, "flasher," "dick," "pitiful"
d. laugh when clients are in crisis/upset
e. have discussions with each other about a client's "business" (behaviors, personal and family history/problems) when/where clients can hear

B. The following are examples of specific client reports related to the facility's living environment:

1. Review on 7/9/18 of Client #2's record revealed:
- Admission date of 6/23/18.
- Age = 11
- Attention Deficit Hyperactivity Disorder (ADHD;) Oppositional Defiant Disorder; Bipolar Disorder; Asthma; History of Sexual Abuse (Victim)

Interview on 7/6/18 with Client #2 revealed:
- He does not feel safe in the facility since staff moved him from unit with clients ages 6 - 12 to the unit with clients ages 13 - 17 as a punishment.
- "I was "fighting younger kids."
- The following are other reasons he feels unsafe on unit with older clientts (ages 13 - 17) :
1. Clients are all older.
2. Staff "yell" at clients and scream when they

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restrain them.
3. Staff handle clients like they want to intentionally injure/hurt them.
4. Staff allow clients to fight him and make fun of each other.
6. Staff have arguments with each other when client's are present.
- He sees the nurse everyday however, he does not see the facility doctor on a regular basis.
- He continues to receive therapy from the therapist on the unit for clients age 6 - 12. However, he now only sees his therapist approximately once every two weeks.

2. Review on 8/14/18 of Client #5's record revealed:
- Admission date of 3/12/18
- Age = 16 years
- Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder; Depressive Disorder, Unspecified and Autism Spectrum Disorder

During interview on 7/26/18, Client #5 reported:
- He has not had privacy when speaking to guardians, social workers or anyone, including his therapist, during the six months he has been in the facility.
- "You can't get any therapy around here."
- Staff create an environment of fear. Staff "instigate," "intimidate," provoke and threaten clients to act out so they can restrain them.
- He does not receive therapy on a weekly/regular basis.
- He has not met with the psychiatrist in 3 weeks.

3. During interview on 7/26/18, another client reported:
- Staff argue with each other when clients are present.

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V 314	Continued From page 31 - He also witnessed a male staff push a female staff to the ground. 4. Interview on 8/16/18 with another current client's parents revealed: - Staff do not assure the facility consistently offers a therapeutic and supportive environment for clients. - Therapy sessions were canceled without her knowledge and without a rationale. - The facility terminated therapist, did not inform her nor her son and "made no effort to allow us closure." - He was "really doing well" with the therapist prior to her termination. - They have not had family therapy and her son has "regressed a lot" in the two weeks since the therapist was terminated. - Parent reported the client has: 1. began to isolate himself to remain in room. He requested QP #1 place him on Non-group Participation (NGP) to avoid interaction with other clients and parents. 2. does not feel staff support him. Staff call him "rapist"and allow other client's to call him derogatory names. 3. hesitated to meet with Substance Abuse (SA) therapist, who reportedly told client the allegations of verbal abuse did not make sense and he did not believe him. 5. A current 17 year old client reported he was placed on NGP for 30 days. - He was prohibited from making any phone calls during that time period. - The prohibition included calls to his guardian, therapist and social worker. C. The following are examples of concerns related to the availability of psychiatric/medical	V 314		

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V 314	Continued From page 32 services in the facility: 1. During further interviews in the survey period from 5/30/18 - 8/16/18, facility RN's reported the following regarding medical/psychiatric services for clients: - They are primarily responsible for management and coordination of client's medical care. - The Medical Director "rarely comes" and the facility Registered Nurses' (RN) frequently have difficulty contacting him and/or getting return calls. - Clients do not have weekly contact with the facility's physician. - The Medical Director reviews client's response to medications and treatment interventions primarily through the facility RN's weekly client reports and signs documentation for authorization of restrictive interventions when he comes to the facility. - On 8/14/18, reported the Medical Director's last visit to the facility was in July, approximately three weeks ago. 2. During interview on 8/20/18, a clinical service provider from a local psychiatric hospital reported: - Hospital team were unable to connect with facility management staff and psychiatrist after multiple attempts for "several weeks" to discuss needs of a potential client. - Specifically requested facility psychiatrist/Medical Director be present on 8/13/18 for a pre-set, pre-admissions phone conference for the potential client. - Initially received misleading information from facility about availability of psychiatric services for clients. - Ultimately staff informed provider the facility did not have a psychiatrist. - Facility was planning to admit the client even	V 314		

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V 314	Continued From page 33 though they could not verify psychiatric and educational services necessary to meet the client's needs were available. - Due to the misdirection and lack of clarity about therapeutic, psychiatric and educational resources necessary to meet the client's needs, the clinical service provider/hospital had to seek another placement for the client. Review on 8/23/18 of the Plan of Protection completed by the facility's Executive Director revealed: What will you immediately do to correct the above violations in order to protect clients from further risk or additional harm? 10 NCAC 27.G 1901 Scope: 1. The care coordinators and nursing department will collaborate with the agency psychiatrist/Physician along with agencies within the child's catchment area to ensure the services are being provided in a uniform manner. How: a. The medical needs and collaboration with agencies will be reported in each Child and Family Team meeting. Input will be requested from the participants and the feedback will be documented. b. The medical and mental health needs related to coordination of services will become a goal on each Person Centered Plan to be review as part of the treatment process. c. Upon admission, the agency will make every effort to gather information related to services and agencies from the child's catchment area that previous services have been provided. d. As part of ongoing treatment and preparation for discharge, the care coordinators will assist the family/guardian and MCO care coordinators identify services at agencies in the child's catchment area to ensure appropriate hand-off communication upon discharge. The information will be documented and reflected in the chart.	V 314		

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V 314	Continued From page 34 10A NCAC 27G. .0204 Competencies and Supervision of Paraprofessionals: 2. Each employees competency shall be evaluated. This will occur through job shadowing and observation. Based on the evaluation a training plan will be put in place. A monthly training schedule will be developed to assist staff with ongoing training to include on the job training. 10A NCAC 27G .0208 Client Services: 10A NCAC 27 .0209 Medication Requirements 3. The agency has reached out to a local Pediatrician to develop a contract to provide medical treatment to the clients outside the facility to include weight of the children. The children that have difficulty maintaining weight and/or gaining weight will have a treatment plan developed based on the guidance and feedback from the Pediatrician. 10A NCAC 27 .0209 Medication Requirements: 4. The agency has scheduled an interview with a Child Psychiatrist on 8/23/18 to assist with provided medical care to the clients at the facility. b. Disposable cups have been purchased and being utilized for medication administration. Once the medications have been distributed the cups will be discarded. GS. 131E-256 Health Care Personnel Registry: 5. The Executive Director will execute a Health Care Registry report on any staff engaged in a violation at the facility. 10A NCAC 27G. 1902 - Staff 6. The agency is currently in the process of interviewing Psychiatrist to gain employment of a Board Certified Child Psychiatrist to provide management and oversight of medical services. b. The Facility Manager will check each shift to ensure appropriate coverage. 10A NCAC 132 .0102 Investigating and Reporting Health Care Personnel:	V 314		

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V 314	Continued From page 35 7. Any report involving a staff member will be reported to the NC Health Care Registry by the Executive Director. Any incident report that is a level II or higher will be reported to the IRS. An investigation shall completed of all incident reports and documented. 10 NCAC 27G. .0604 Incident Reporting Requirements: 8. Any incident report that is a level II or higher will be reported to the IRS. An investigation shall be completed of all incident reports and documented. 10A NCAC 27D & F .0101 Policy on Rights Restrictions and Interventions: 9. Staff will be trained on the Policy listed in this section. The staff will be monitored and all restraints shall be reviewed with all staff involved. The review will consist of the administrative staff interviewing the steps utilized by staff and determination of continued employment will be reviewed. The facility failed to employ a Medical Director who was a psychiatrist with experience in the treatment of the population being served. This resulted in Client #3 being without a prescribed medication and the timely follow up on tests for Client #6 to determine possible toxic levels of his medication. Clients in the facility was subjected to physical restraint techniques by facility staff that was not approved and caused bruising and serious injury to clients #5, #9, #11, and FC#1 and subjected Clients #3, #7 and #10 to the possibility of serious injury. Facility staff on several occasions used restrictive intervention as a first resort to prevent or defuse client's behaviors of agitation, verbal outburst and property destruction. The ED placed Client #2 in the same unit with older clients as a consequence for his behavior of	V 314		

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bullying and assaulting younger clients. As a result of him moving to a new unit with older clients, Client #2 was subjected to the same aggressive behaviors he engaged in with the clients his own age and younger getting a black eye, as well as some sexually inappropriate behaviors between Client #2 and other clients on the unit. Facility staff cursed, talked negatively and use sexually derogatory terms towards the clients. QP#1 used fear and intimidation through verbal threats to respond to Client #6's inappropriate sexual behaviors. Facility staff also subjected clients to verbal abuse and the use sexually derogatory terms. Facility staff also encouraged clients in the facility to bully, name call and to engage in inappropriate teasing and touching of other clients in the facility. The facility did not employ the required number of qualified professionals (Clinical Director and QP) and staff for each residential unit with 12 clients which resulted in limited staff to provide adequate supervision for clients.
The QP #1 and ED did not conduct timely internal investigations into allegations of physical and verbal abuse by staff and into circumstances surrounding multiple abrasions, bruises and injuries sustained by FC#1 and Client #2.

The failure of the facility to provide a structured living environment and staff trained to provide adequate supervision in a treatment program with specialized interventions subjected all clients to serious harm, abuse and neglect. This deficiency constitutes a Type A1 rule violation for serious harm, abuse, and neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of

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V 314	Continued From page 37 compliance beyond the 23rd day.	V 314		
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction 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 PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities 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 record reviews, interviews and observation, the facility failed to: 1) employ a Medical Director who was a physician who was board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness and 2) assure at least two direct care staff members were present at all times with every six children or adolescents in each residential unit. The findings are:	V 315		

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V 315	Continued From page 38 A. The following information is in reference to the requirement for a PRTF to operate under the direction of a psychiatrist. Review on 8/10/18 of the job description for facility's medical director/psychiatrist revealed: - Minimum education, training and experience requirements for "A four year post graduate psychiatric residency" - Responsibility for 75% of the physician's time to be spent in "direct care" and included the following : 1. Assuring standards and expectations are consistently met in the facility's "therapeutically structured interventions" - "structured living environment, therapeutic interventions, and supervision" for clients. 2. "diagnose nature and extent of mental disorder" 3. "prescribe, direct, and administer psychotherapeutic treatments or medications to treat mental, emotional, or behavioral disorders" 4. collaborate with other qualified professionals providing services to clients to discuss treatment plans and progress 5. advise and inform guardians and other professionals of client conditions and treatment 6. "design individualized care plans, using a variety of treatments" 7. provide "weekly consultations" to each client in facility - Facility's current Medical Director signed job description on 1/5/16 as a "Psychiatrist." Requests were made on 7/9/18 through 8/15/18 for information where the facility's physician could be contacted. All request were unsuccessful. - Consequently, surveyor obtained information from the internet with the following outcomes:	V 315		

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V 315	Continued From page 39 1. Office address and phone number of a practice located in another city. 2. "Internal Medicine" identified as physician's practice specialty. No identification of certification in psychiatry or practice with children and adolescents. - Additionally, call to office identified as facility physician's office revealed: 1. No psychiatric nor children/adolescent services ever provided 2. Physician's association and practice in that location had been discontinued 3. Facility's phone number was provided to persons/patients for follow-up/future contact with the physician Interview on 7/9/18 with the facility's nurses revealed: - They are primarily responsible for management and coordination of client's medical care. - They were unable to confirm that the facility Medical Director was a psychiatrist. During interview on 8/20/18, a clinical service provider from a local psychiatric hospital reported: - Hospital team attempted to contact the facility's psychiatrist/Medical Director to discuss a potential client. - Team was unable to get response from facility or connect with facility's Medical Director after multiple attempts and several weeks. - Specific request was made for facility psychiatrist/Medical Director to be present on the 8/13/18 pre-admission phone conference for a potential client. - During phone conference, facility staff reported they "did not know," if facility's Medical Director was a psychiatrist and needed to contact the facility Medical Director to check. - Facility's Lead Nurse ultimately confirmed the	V 315		

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V 315	Continued From page 40 facility's Medical Director was not a psychiatrist. Interview on 8/16/18 with the facility's Medical Director revealed: - He has been Medical Director of the facility since they began admitting clients. - He makes an effort to come to the clinic weekly to manage client's medications and medical issues however, he may not see every client. - He tries to meet with client's "at least once a month" to review mental/psychological and emotional health concerns they are experiencing. - He is not a psychiatrist and "about 20%" of his medical practice is with children and adolescents. However, he is "trying to" help the facility find a psychiatrist. NOTE: A request was made to speak with the Medical Director after he completed client contacts. However, ability to interview was very limited. Medical Director was departing the clinic when surveyor was able to approach him and was allowed opportunity for very brief contact outside of the facility. During interview on 8/21/18, the Licensee said: - The physician told facility management he was a psychiatrist. - The facility's job description for Medical Director identified a degree in psychiatry and experience in working with children with mental health diagnoses as the primary qualification for the position. - He was not aware the current physician in the position was not a psychiatrist. B. The following is in reference to staff ratio requirements for the PRTF Observation during the survey period on 7/9/18 of the facility revealed:	V 315		

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V 315	Continued From page 41 - Facility had two separate but connected units. Each unit has a capacity for 12 clients: one unit for ages 6 - 12 and one unit for ages 13 -17. - Each unit contained one common area separate from bedrooms in which clients generally remained all day for all activities, i.e.: education; group counseling; dining/meals; social/entertainment; and sometimes administration of medications. Interview on 7/9/18 with the Shift Lead #1 revealed: - He is responsible for scheduling staff to work each shift. - He "usually" has four or five staff, including himself, working during each day and afternoon shift. - Three or four staff work the overnight shift. They are awake staff. - The Shift Lead acts as a "floater" between the two units to monitor staff and provide support when either Shift Lead is not able to work. - He was currently monitoring both units as a "floater" because the Shift Lead for the unit with ages 13 -17 is not available. Observation on 7/9/18 at 2:25 PM revealed: - All clients were present and directed to their rooms for "Quiet Time." - Only three direct care staff were present on unit with clients ages 6 - 12 in addition to the Shift Lead who was not available when he moved to monitor/supervise staff and clients on unit with ages 13 - 17. Interviews with facility nurses on 7/26/18 - 8/16/18 revealed: - All nurses in the facility are Registered Nurses (RN) and work 12 hour shifts - 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM.	V 315		

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V 315	Continued From page 42 - They remain on the unit where client bedrooms are located and are available during all three staff shifts. - During the day shifts there are "usually four to five" direct care staff present with the clients. - During client's sleep hours, on the night shift, "at least three"direct care staff are present on the unit. - They identified some third shift staff who were found "sleeping all the time." Review on 8/14/18 of the facility's August 2018 work schedule for staff' for each unit revealed: - Facility scheduled staff in three shifts each day of the week. - Generally, a minimum of four staff names were identified for each shift on every day of the week. The following were examples of when only three staff were scheduled to work on the overnight shift from 12 midnight to 8 AM: 6/12; 6/14; 615; 6/16; 6/17; 6/18 and 6/25. During interview on 8/14/18, the Licensee said: - They call "fill-in" staff to work on those shifts and days when there are no staff scheduled. During additional interview on 7/9/18, the Shift Lead #1 for unit with clients ages 6 - 12 confirmed: - Only three direct care staff might be available to provide supervision for clients on the unit when it was necessary for the Shift Lead to cover both units. - Additionally, on occasion, the overnight shift is covered by only three direct care staff. This deficiency is cross referenced into 10A NCAC 27G .1901 SCOPE (V314) for a Type A-1 rule violation and must be corrected within 23 days.	V 315		

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V 317	27G .1904 Psych. Res. Tx. Fac. - Transfer or Discharge 10A NCAC 27G .1904 TRANSFER OR DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The PRTF shall meet with existing child and family teams and other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other representatives involved in the care and treatment of the child or adolescent including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge the child or adolescent as soon as the emergency situation is stabilized. (e) In case of an emergency, notification may be by telephone. A service planning meeting as set forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge.	V 317		

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V 317	Continued From page 44 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to discharge 2 of 2 audited former clients (FC #1 and FC #4) according to their policy and requirements of the rule. The findings are: Review on 8/16/18 of the facility's discharge policy revealed the facility's policy included the following requirements: 1. Discharge of clients would not occur "without advance written notification of the treatment team, including legally responsible person." 2. A meeting would be held with all persons and entities involved prior to the any planned transfer or discharge "to make service planning decisions." 3. Conduct a service planning meeting conducted within five (5) business days of the emergency discharge or transfer. 4. Include Executive Director (ED,) Qualified Profession (QP) and/or Clinical Director in the decision-making process to discuss the potential for any unplanned discharges, possible alternatives for preventing discharge discuss 5. Consultation with the Medical Director Review on 5/24/18 of Former Client (FC) #1's record revealed: - Admission date of 5/3/18. - Diagnoses of Intermittent Explosive Disorder; Oppositional Defiant Disorder with Anxious Distress; Sensory Processing Disorder and History of Head Injury (Per UNC Health Care - 3/13/18.) - Removed from facility (discharged) on 5/19/18	V 317		

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V 317	Continued From page 45 at request of parent after he "has only been in the program for 17 days." Review on 7/9/18 of FC #1's Discharge Summary revealed: - Completed and signed by the Qualified Professional (QP) #1 on 5/19/18 - Removed from facility (discharged) at request of parent after he "has only been in the program for 17 days." - Did not "have a chance to comply with the program" Further review on 7/9/18 of the Discharge Summary for FC #1 (provided after a request from surveyor) revealed an "Addendum" dated 5/19/18 documenting: - QP #1, ED and a facility nurse completed and signed the document: - Parent "refused to sign any of the discharge documents" - Parent "would not listen to advice of the staff" - Persons notified of the emergency discharge were identified as client's therapist, care coordinator and Licensee. Interview on 5/25/18 with FC #1's parent revealed: - She did not receive requested information about FC #1and the facility doctor was never available to meet with her. - She decided to discharge FC #1 and take him to a hospital to obtain emergency treatment for his increasing physical and psychiatric crisis. - She was informed by QP #1 she could not remove the client from the facility. - She did not have any further contact from facility staff after she took client from facility. - She had not received the requested records.	V 317		

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V 317	Continued From page 46 Review on 8/9/18 of FC #4's record revealed: - Admission date of 7/3/17. Discharge on 6/15/18 - Post Traumatic Stress Disorder; Attention Deficit Hyperactivity Disorder; Conduct Disorder; Persistent Mood Disorder and Cannabis Use Disorder - Guardian was FC#4's home county Department of Social Services (DSS) Review on 8/15/18 of documentation from FC #4's DSS guardian revealed: 1. 4/4/18 Child and Family Team (CFT) began discussion with facility staff on transfer of FC #4 to lower level of care. Projected discharge on 6/1/18. 2. 4/24/18: FC #4's Care Coordinator forwarded documentation noting PRTF sent information on client to the proposed transfer facility. 3. Communication and request for updated documents needed for discharge from 4/24/18 until 6/13/18 included: a) 4/24/18 - forwarded request to QP #1 for updated documents. Initial information sent on was out of date. b) 5/8/18 & 5/31/18 - CFT meetings - Additional request for facility to provide updated information to process transfer request. c) 6/7/18 - QP #1 called discharge of FC #4. Bed "promised to another client." Placement not yet authorized as PRTF had not provided requested updated information. 4. 6/14/18 - QP #1 called to inform immediate pick up FC #4 was necessary. - FC #4 pick up on 6/15/18 and temporarily placed in the lower level care facility until required documentation could be obtained. - Continued contact with the facility for approximately 2.5 weeks in an effort to obtain the documentation. - She never received copies of any	V 317		

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documentation or information PRTF reportedly sent to the proposed facility or the Care Coordinator.
- She was never made aware the facility requested extensions and/or were denied extensions to continue providing service to FC #4
- FC #4 missed one week of school due to the lack of the proper documentation from the PRTF.

Information obtained from the Care Coordinator on 8/17/18 revealed the following contact occurred with the PRTF facility regarding FC #4's discharge:
- 5/8/18: Discussed "projected" discharge date of 6/1/18 for FC #4 and documentation needed from PRTF.
- At request of PRTF, extension was given for PRTF to provide services for FC #4 in their facility through 5/31/18.
- 5/31/18: QP #1 for PRTF informed Care Manager the facility "had an intake schedule" and needed FC #4 to be discharged. She informed PRTF authorization for placement was not yet done due to incomplete documentation. Suggested and approved another extension of services for client from 6/1 -16/18.
- 6/14/18: Received "constant" emails from facility QP #1 requesting update on FC #4's discharge status up through this date. Informed PRTF should request additional extension since authorization was not yet completed. However, QP #1 said FC #4 must be picked up due to the facility had admitted another client and needed the bed.
- Never received FC #4's updated information from PRTF.
- The extensions requested by the facility were "never denied."
- FC #4 DSS social worker removed him from facility on 6/15/18 due to the insistence of the

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facility management staff.
- FC #4 was transferred as an emergency/temporary placement to a lower level of care.

Review on 8/21/18 of the facility's documentation requested by the surveyor related to FC #4's discharge revealed:
- Form signed by facility nurse was not complete. Did not document:
1. treatment recommendations
2. prognosis
3. educational/vocational needs
4. anticipated problems after discharge
- Facility report for last 30 days of client's treatment prior to discharge only documented phone calls from mother and did not include required information on:
1. person's involved and extent of involvement in discharge plan/treatment
2. facility's efforts to include family/guardian in treatment
3. involvement of other agencies
4. PRTF attempts to coordinate services between agencies only documented completion of probation. It did not document any involvement by other agencies such as DSS, Department of Juvenile Justice (DJJ,) case managers and/or court counselors, etc.

- Facility provided the following list of dates of events with supporting documents of activities related to FC #4's discharge/transfer:
1. 4/24/18: QP #1 emailed Level II group home information as directed by Care Manager. "[DSS worker] and [Care Manager] were both included in the email."
NOTE: Review of email provided indicated facility sent an attachment which was identified as "level ii.doc (610.50KB)." There was no indication DSS

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V 317	Continued From page 49 worker and Care Manager were included in the email. 2. 4/28/18: "[DSS worker] and [Care Manager]" informed QP #1 in CFT meeting "that the initial placement with the Therapeutic home fell through" NOTE: No documentation of 4/28/18 CFT meeting was provided. 3. 5/8/18: Facility received email requesting "updated CCA (Comprehensive Clinical Assessment) due to the CCA being a year old and still having PRTF listed.) "[DSS worker] was included in the email." Information sent. 4. PRTF reported a 14 day authorization was "resubmitted on two occasions due to [FC #4] not being picked up by the guardian" FC #4's Management Care Organization - MCO informed Canyon Hills they would not authorize additional time for FC #4 to remain in facility. NOTE: No documentation of denials of extension request was provided. See above report from Care Manager noting PRTF extension granted through 6/16/18 and was never denied. 5. 6/14/18: Facility notified FC #4's DSS worker of the MCO's "discontinuation of authorization for [FC #4] to remain in facility." NOTE: No documentation of notification to DSS worker/guardian was provided. See above report from DSS worker noting she was never made aware of a request from PRTF for extension of service. 6. 6/15/18: DSS worker picked up FC #4. She was given the client's medications and the discharge summary. "[DSS worker/guardian] refused to sign the discharge summary."	V 317		

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V 317	Continued From page 50 Interview on 8/21/18 with the ED and QP #1 revealed: 1. In reference to FC #1: - Parent was a "disgruntled" parent who "chose" to take her son out of facility and refused to sign the discharge paperwork. - QP #1 informed her if she removed client in this manner "There may be further consequences from [Client #1's MCO.]" - Staff felt the facility had been "more flexible" with FC #4's mother and more lenient with the agency policy on visitations which required a "24 hour notice" prior to visitation. - Staff allowed her more calls/contact and visitations with her child prior to the end of the client's 30 day probationary/orientation period. - She was informed of PRTF's policy when FC #1 was admitted. However, "She feels like she should be able to come whenever!" 2. In reference to FC #4: - The facility made every effort for 3 months to assist in the placement and discharge of FC #4. Request on 8/21/18 for additional documentation to support the facility complied with the requirements for discharge did not result in any additional documents. 1. In the case of the emergency/unplanned discharge of FC #1: - management staff provided a copy of a letter dated 5/19/18, reporting the client's "therapist, care coordinator, ED, nursing staff and the Owner were made aware of what happened." - No documentation was provided of a service planning meeting conducted within five (5) business days of the emergency discharge which included persons (other than staff) who were involved with the client. 2. For the "planned" discharge of FC #4,	V 317		

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V 317	Continued From page 51 management staff: - did not provide written notification to the treatment team, including the DSS worker, the legally responsible person. - did not assure all persons and entities involved with the client were included and assisted in making final service planning decisions prior to actually discharging the client.	V 317		
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 record reviews and interviews, the facility failed to report all allegations of abuse against staff, including injuries of unknown source, within 24 hours of the facility becoming aware of the allegation affecting 2 of 18 audited current clients (#5 & #9)and 1 of 2 audited former clients (#1) The findings are: Review on 5/24/18 of Former Client (FC) #1's record revealed: - Admission date of 5/3/18.	V 318		

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V 318	Continued From page 52 - Age = 9 - Diagnoses of Intermittent Explosive Disorder; Oppositional Defiant Disorder with Anxious Distress; Sensory Processing Disorder and History of Head Injury. - Removed from facility (discharged) on 5/19/18 at request of parent after 17 days. Interview on 5/25/18 with FC #1's parent revealed: - On 5/12/18 she visited FC #1 and found "a very large bruise and abrasion on his arm." - Staff informed her the injuries were self inflicted and/or caused when he attacked other clients. - On 5/13/18, FC#1 alleged Staff #1 pushed him into his bed and caused the bruise on his arm. - On 5/13 - 14/18 she informed the Qualified Professional (QP) #1 of the allegation and requested the facility conduct a formal investigation. - On 5/19/18 further alleged the Lead Staff-B "spit in his own hand and smashed it all over (FC #1's) face, then kicked him in his private part calling him an ass-hole." - Both the QP #1 and ED were present when FC #1 made the allegations. (See Tag V367 for more details) Review on 8/14/18 of Client #5's record revealed: - Admission date of 3/12/18 - Age = 16 years - Diagnoses of Oppositional Defiant Disorder (ODD;) Attention Deficit Hyperactivity Disorder (ADHD;) Depressive Disorder, Unspecified and Autism Spectrum Disorder During interview on 7/26/18, Client #5 reported: - On 6/14/18, he reported to the nurse that he felt staff abused him when they restrained him. - On 7/28/18, staff restrained him without notifying	V 318		

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V 318	Continued From page 53 the nurse. He told the Executive Director (ED) staff abused him. Review on 8/14/18 of Client #9's chart revealed: - Admission date of 5/29/18 - Age = 7 - Diagnoses of ADHD; ODD and Conduct Disorder - Childhood Onset. Interview on 8/14/18 with a nurse revealed: - Client #9 reported to the nurse with signs of significant older bruising on both sides of his abdomen. - The client said he received the bruises when staff restrained him approximately one week ago. - He reported Lead Staff #1 "put him on the wall" to restrain him. - Nurses were not called for authorization and were not present during the restraint. - Nurse who examined the client was not involved in the restraint and thus did not document the restraint. - The nurse was not aware if the incident was reported to HCPR. Review on 7/9/18 and 8/16/18 of the incident reporting system revealed: - A report on one of FC #1's allegations was submitted to the Department on 6/7/18 and only documented the allegation dated 5/19/18 against the Lead Staff #1. The report was not completed and submitted within 24 hours as required. - No report was found documenting the allegation Lead Staff #1 caused bruises to Client #9's abdomen during a restraint. - No documentation was found the facility conducted an internal investigation to determine the source of the bruises Client #9 alleged occurred as a result of the restraint.	V 318		

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V 367	Continued From page 54	V 367		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously	V 367		

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V 367	Continued From page 55 unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that	V 367		

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V 367	Continued From page 56 meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all Level II incidents. The findings are: Review on 8/14/18 of the facility's incident reporting process revealed the following: - Nurses are responsible for documenting all incidents, regardless of level. - Nurses are also responsible for documenting all physical restraints. - Staff should call the nurse prior to restraining a client when possible and the nurse should be present during a restraint. - Documentation of incidents and physical restraints may be based only on verbal report from staff if a nurse does not witness the incident/restraint. - Formats for documenting incidents included: 1. Incident Report/Vital Signs Log Book 2. Restrictive Intervention Order/Follow-up Form - filed by client name. Review on 8/14/18 of the "Incident Report/Vital Signs Log Book" for clients revealed: - Documentation of 13 restraints from 1/6/18 through 7/4/18 for clients age 13 - 17 - The log book documented client's name, length of time restraint was implemented and nurse present. - A description of the restraint and other required details were not included.	V 367		

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V 367	Continued From page 57 Review on 8/14/18 of the "Restrictive Intervention Order/Follow-up Forms" revealed: - Documentation of 13 restraints from 1/6/18 through 7/4/18 - All restraints were authorized by telephone call to the facility Medical Director. - 7 (seven) of the restraints were documented in the above log and provided additional details related to the circumstances of the restraint. However, the facility forms did not include all required documentation. The following are examples: 1. Telephone order for authorization on 3/15/18 - " Fourteen (14) minute therapeutic hold to prevent consumer from harming himself. Spit, profanity, racial slurs, fighting. Threatened to kill staff. Consumer said his arms were sore. Redness noted to both arms. Refused pain medication. Staff acted quickly and appropriately to prevent consumer from further property destruction." - Facility doctor signed dated 3/23/18. 2. Telephone order for authorization on 6/1/18 - "After taking meds, consumer started walking to his room. Prompted by [Staff #7] to step back to community area. (Must remain up front in community area for 15 minutes after med administration. Stated he was not going to. Slammed bedroom on [Staff #.7] [Staff #7] opened door. Attempted to punch [Staff #7.] Placed in a two-man hold by [Staff #7 & Staff #3] for 5 mins. Continued to use profanity, yell and scream. Attempting to jump around and kick staff. Nurse prompted to calm down. Said he was trying to. Nurse prompted staff to release consumer. He sat on bed. Continued to yell and scream verbal insults to [Staff #7.] Jumping around and flinging his body up against the wall. Placed in 2-man hold for 5 mins. After release - sat on bed,	V 367		

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banged head against the wall. Prompted to stop. Stopped and sat on bed. [Staff #3] continued to process with consumer. He calmed down. Complained arm was sore. Refused offer of something for pain. Abrasions/reddened areas noted to left arm/under arm, right arm, chest area and back. Nose red and bleeding."
- Facility physician signed dated 6/6/18

3. Telephone order for authorization on 6/2/18
- "Consumer was pulling at window. Stated he was going to escape and cut staff with piece of Plexiglas. Consumer was hostile and aggressive towards staff. Consumer balled up his fists and started walking towards staff who were trying to process with him. Staff placed consumer in a 5 minute therapeutic hold until tension reduction was reached. Description of events leading to restrictive intervention: Physical and verbal aggression towards staff. Attempting to destroy property to attack staff. Client Debriefing: No. He didn't want to talk about it. Staff acted appropriately."
- Facility physician signed dated 6/6/18

4. Telephone order for authorization on 7/4/18
- "Consumer was verbally and physically aggressive towards staff and peers, flipping over chairs. Two man therapeutic hold. Consumer was arguing and throwing punches at a peer. Staff separated consumer. Consumer flipped over chair and attempted to turn over chair, consumer hit staff member and was removed from community area and placed in a 5 minute therapeutic hold until tension reduction was met. Refused debriefing. Staff acted appropriately."
- Physician signed on 7/6/18.

Interview on 7/26/18 with the Shift Lead #2 revealed:

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V 367	Continued From page 59 - Staff "usually" get the nurse to come in when a client is restrained. - The nurse "may not see the restraint itself." - However, she documents the restraint "based on staff report" of the incident. Interview on 7/26/18 - 8/21/16 with a nurse revealed: - Staff should call the nurse prior to restraining a client, unless the restraint is an emergency. - Staff should call for "back up" staff so there are two staff at all times when they restrain a client. - Staff have improved in calling the nurse for incidents and before they implement a restrictive intervention. - Previously, staff "might call" her after they did a restrictive intervention. - When staff did not contact her before or during a restrictive intervention, the nurse said "I will not write it 'cause I didn't see it." Interviews on 7/26/18 - 8/21/16 with asecond nurse revealed: - All incidents and all restraints must be documented by the nurse on duty. - Some staff will restrain the clients before trying to "calm them down by talking first." - "I tell them not to get into a verbal contest with kids. They still do. They don't know how to talk to kids." - Staff want to restrain clients without calling the nurse to get authorization. - Reportedly, Staff #2 will give clients candy so they will not tell when they have been restrained. - She found bruises on both sides of 10 year old client's abdomen after Lead Staff #1 restrained him. However, the nurses were not present during the restraint. Therefore, the restraint was not documented.	V 367		

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V 367	Continued From page 60 Review on 8/14/18 of Client #5's record revealed: - Admission date of 3/12/18 - Age = 16 years - Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder; Depressive Disorder, Unspecified and Autism Spectrum Disorder During interview on 7/26/18, Client #5 reported: - On 6/14/18, he reported to the nurse that he was restrained and felt staff had abused him. - On 7/28/18, staff restrained him without notifying the nurse. He told the Executive Director (ED) staff abused him. Review on 8/16/18 of Client #12's record revealed: - Admission date of 4/24/18 - Age = 6 years Interview on 8/16/18 with Client #12's Case Manager revealed: - Client was restrained on 7/21/18 after he hit, kicked and bit staff. - Facility Qualified Professional (QP) #1 informed Case Manager a report was submitted to IRIS and available to the local management entity. - She requested the facility's documentation however, QP #1 said the facility does not document incidents and/or behaviors in the facility's system if the incident was reported to IRIS. - However, as of 7/24/18, the incident was not on IRIS. Review on 7/26/18, 8/16/18 and 8/21/18 of the facility's incident reporting logs and the State system for reporting Level II incidents revealed: - The above incidents were not found on the State's required reporting system	V 367		

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V 367	Continued From page 61 - However, upon request for copies of all Level II incident reports, the facility's Executive Director provided a five "Incident Review" sheets documenting a client name and "incident number" as proof incidents reports submitted to IRIS from May 2018 through August 2018: 6/24/18; 6/27/18; 7/17/18 x 2 and 7/25/18. This deficiency is cross referenced into 10A NCAC 27G .1901 SCOPE (V314) for a Type A-1 rule violation and must be corrected within 23 days.	V 367		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use.	V 513		

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V 513	Continued From page 62 This Rule is not met as evidenced by: Based on record reviews, interviews and observations, facility management failed to assure 8 of 20 audited staff (Lead Staff #1; Shift Lead #2; Staff's #2; #3; #4; #5; #6 & #7): a) used approved restrictive intervention methods; b) used the least restrictive and most appropriate intervention; c) used actions designed to insure dignity and respect during the intervention and d) used restrictive intervention as a last resort. The findings are: Review on 5/30/18 of Lead Staff #1's personnel file revealed: - Hire date of 3/18/18 - Works as Lead Staff for clients ages 6 - 12 Review on 8/14/18 of Shift Lead #2's personnel file revealed: - Hire date of 5/31/17 - Currently works as Shift Lead Staff for clients ages 13 - 17 Review on 8/21/18 of Staff #2's personnel record revealed: Hire date of 8/16/18 Review on 8/14/18 of Staff #3's personnel file revealed: - Hire date of 8/28/17 - Currently works as direct care staff on 2nd shift with clients ages 6 - 12 - Recently moved from working with clients ages 13 - 17 Review on 8/14/18 of Staff #4's personnel file	V 513		

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V 513	Continued From page 63 revealed: - Hire date of 11/15/17 - Currently works as direct care staff on 2nd shift with clients ages 6 - 12 Review on 5/30/18 of Staff #5's personnel file revealed: - Initially hired on 1/3/17 as direct care staff. - Also worked as Senior Team Leader clients ages 6 - 12 Review on 8/14/18 of Staff #6's personnel file revealed: - Hire date of 11/10/17 - Works as direct care staff on 2nd shift with clients 13 - 17 and clients ages 6 - 12 Review on 8/14/18 of Staff #7's personnel file revealed: - Hire date of 1/8/18 - Works as direct care staff with clients ages 13 - 17 Interview on 5/24/18 and 6/7/18 with local police officers revealed: - They were in the process of conducting several investigations in the facility related to client allegations of staff abuse. - During interviews, clients said staff restrained them using methods clients described as "the chicken" and/or "the wall." The following are client descriptions which are representative of "the wall" and "the chicken." Review on 7/9/18 of Client #2's record revealed: - Admission date of 6/23/18. - Age = 11 - Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD;) Oppositional Defiant Disorder;	V 513		

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V 513	Continued From page 64 Bipolar Disorder; Asthma; History of Sexual Abuse (Victim) During interview on 7/6/18, Client #2 gave the following description of the restraint which occurred after he was moved to the unit with clients age 13 - 17: - Two staff restrained him because he would not sit down on his bed. - Staff #3 pulled his arm behind his back during the restraint. - Staff put him face down on the bed and held his legs apart. Interview on 8/14/18 with the social worker for Client #2 revealed: - Client reported staff put him in an "illegal hold" and could have broken his arm. - Only one staff was present and no other staff were in the area. - She was not always informed when staff restrained the client. Interview during survey period from 7/9/18 - 8/16/18 with facility Registered Nurses revealed: - Most (restraints) could be avoided. However, staff do not know how to verbally calm the clients. - Staff use the threat of a restraint to control client's behavior. - Staff also stand in the doorway of the client's room to block them from leaving the room. - Lead Staff #1 and Staff #2 were observed picking smaller clients up and shoving them into their rooms. During the survey from 7/6/18 - 8/16/18, clients described the following related to restrictive interventions: - One client refused to describe whether he had been restrained or been present when other	V 513		

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clients were restrained. "I'm not a snitch. They said they gon' come and get me again if I say something."
- Another client said two staff restrained him during the 2nd shift. "They put me up against the wall and held my arms up with my feet off the ground."
- Multiple clients consistently identified Staff #3 and Staff #4 "the worse" staff when restraining them:
a. During restraint the two staff were described as using a harsh tone of voice; vulgar language and "trying to hurt us."
b. Restrain clients first rather than talking to them

Review on 7/12/18 of information provided by a Former Staff confirmed:
- She worked with clients age 13 - 17 until June 2018.
- She was present when a former 16 year old client was being restrained.
- The former client complained that staff were making his "bones crack." He was "surrendering and crying."
- He asked staff to stop, however he was not released from the restraint.
- Staff #7 and Shift Lead #2 restrained the former client.

Review on 8/14/18 of Client #5's record revealed:
- Admission date of 3/12/18
- Age = 16 years
- Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder; Depressive Disorder, Unspecified and Autism Spectrum Disorder

During interview on 7/26/18, Client #5 reported:
- Staff often scratched and bruised him during restraints.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-158	A. BUILDING: _____ B. WING _____	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS TREATMENT FACILITY	769 ABERDEEN ROAD RAEFORD, NC 28376

(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 513	Continued From page 66 - On 6/14/18, he reported to the nurse that he felt staff had abused him. - Staff #7 "instigates" and restrained him without the nurses's authorization. - On 7/28/18 he was restrained without the nurse being notified. He told the Executive Director (ED) staff abused him. - Staff #7 restrained him until he lost all sensation in his arms: The following is his description of the restraint: a. The staff pushed and held him against the wall with his arms stretched out and twisted backwards. b. His feet were not touching the floor. c. He told them he was in pain however, they did not release him. d. "I couldn't feel my arms for about 15 seconds. My blood circulation was cut off." - The nurse examined his bruises after the restraint. She told him the bruises were "just because I was white." Review on 7/9/18 of Client #3's chart revealed: - Admission date 1/29/18 - Age = 9 - Diagnoses of Bipolar Disorder - Unspecified Type; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder (ADHD) - Unspecified Type During interview on 8/16/18, Client #3 reported: - Staff #5 and Staff 6 restrained him by pressing him up against the wall. - He was facing the wall with his hands twisted behind his back. Review on 8/16/18 of Client #10's record revealed: - Admission date 1/8/18 - Age = 10	V 513		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-158	A. BUILDING: _____ B. WING _____	10/23/2018

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V 513	Continued From page 67 - Diagnoses of ADHD; Anxiety; Seasonal Allergies During interview on 8/16/18, Client #10 reported: - One staff person restrained him on his 1st and 2nd day in the facility. - The staff person put him up against the wall. - His arms and hands were pulled up behind his back during the restraint. - He said "It hurt!" - He told the staff he was in pain however, the staff did not change the way he was restraining the client nor release him. - His roommate [#3] was present. However, he was moved to another room because of his behaviors. - Client was unwilling to give the name of the staff who restrained him. Review on 5/24/18 of Client #7's record revealed: - Admission date of 11/22/17 - Age 9 - Diagnoses of ADHD; Major Depressive Disorder; Abuse/Neglect (Victim) Observation on 8/14/18 at 6:15 PM of a restraint on Client #7 revealed the client restrained in his room by two male staff. A description of the restraint follows: - A male staff on each side of the client's body pressing him against the wall with client facing the wall. - One staff held each arm - one arm was extended, pulled to the side and twisted with his palm facing outward away from the wall; the other arm was extended and held behind his back in a flexed/bent position. - Client was yelling and screaming for release. - Nurses were present during the restraint. Review on 8/14/18 of the incident report for the	V 513		

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 513	Continued From page 68 above incident witnessed by surveyor revealed: - Incident was documented on facility form as a Level II incident - "Two man restraint for 15 minutes" - Reason for restraint: "due to being given 2 soft tacos for dinner and other clients had hard tacos." - Nurse documented client was checked after restraint however, other required information was not documented. Additional review on 8/14/18 of staff training in restrictive intervention revealed: - All staff had documentation they were currently trained in alternatives to restrictive intervention and approved intervention techniques. - Review revealed no physical restraint techniques which involved methods like those described above by the police and clients: i.e. - "the chicken" and "the wall." This deficiency is cross referenced into 10A NCAC 27G .1901 SCOPE (V314) for a Type A-1 rule violation and must be corrected within 23 days.	V 513		