Division of	of Health Service Regu	lation			1 OI (W	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SU COMPLE		
		MHL047-158	B. WING		C 01/0	5/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
CANYON	HILLS TREATMENT FAC	II ITY	RDEEN ROAD RD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
V 112	2021. The complaint #NC00172146) were complaints (intake #N #NC00172733) was understand Deficiencies cited. This facility is license category: 10A NCAC Psychiatric Resident Children or Adolescel 27G .0205 (C-D)	IC00172881 & unsubstantiated. d for the following service 27G. 1900 Treatment Facility for hts	V 112			
	V 112 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

DIVISION	of Health Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
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		MHL047-158	B. WING		01/0	5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
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CANYON HILLS TREATMENT FACILITY			D, NC 28376			
			<u>, </u>			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
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			1,,,,,			
V 112	Continued From page	e 1	V 112			
	This Dula is not most	an avidenced by				
	This Rule is not met					
		ew and interviews the facility				
	•	amily therapy goals identified				
		ent plan or service plan for				
	one of one audited cli	ient (#1). The findings are:				
	Review on 12/21/20 of	of Client #1's record				
	revealed:					
	-Admission date: 3/4/					
	•	on Deficit Hyperactivity				
	Disorder, Combined F	Presentation, Conduct				
	Disorder, Childhood,					
	Child Sexual Abuse,	Confirmed, Perpetrator of				
	Child Non-parental S	exual Abuse, Persistent				
	Depressive Disorder	(Dysthymia) with Anxious				
	Distress by History.					
	-Treatment Plan date	d 12/20/20 revealed the				
	following goal and pro	ogress toward goal and				
	justification revealed:					
	-"[Client #1] will a	actively participate in family				
		rt therapy at least once a				
		ongoing throughout treatment				
	to encourage an impr					
		o COVID-19 family sessions				
	have been limited"	,				
		o the COVID-19 family				
	sessions are still limit					
		will continue due to				
		dual sessions. Family				
	sessions will be done	_				
		o COVID-19 pandemic family				
	merapy sessions are	done virtually or by phone."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED		
MHL047-158		B. WING		0.	C 1/ 05/2021		
	ROVIDER OR SUPPLIER HILLS TREATMENT FAC	ILITY 769 ABE	DDRESS, CITY, STATI RDEEN ROAD D, NC 28376	E, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 112	-"8/17/20 - Due to therapy sessions are phone."	the last child and family #1] has had multiple family e sessions have been due to the COVID-19 Int #1] has participated in last 30 days. Due to are limited and conducted via to COVID-19 pandemic as are conducted virtually or goal has been paused, ted that [client #1] does not a issues with mom via the continued when the family return.999 With Client #1's parent was client #1's therapist, plete therapy in total before nome. Attended to court and family the therapist during CFT	V 112				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
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		MHL047-158	B. WING		01/05/2021
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NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
CANYON	HILLS TREATMENT FAC	ILITY	RDEEN ROAD		
		RAEFUR	D, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE COMPLETE
V 112	Continued From page	3	V 112		
	-"Maybe we have dro therapy." -We had started movi	pped the ball on family ng forward with it by virtual ought to their attention.			
V 314	27G .1901 Psych Res	s. Tx. Facility - Scope	V 314		
	10A NCAC 27G 190°	1 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 require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or				
	mental health therape	lized substance abuse and eutic care. These ons and services shall be			
	designed to address to necessary to facilitate community setting.				
	for whom removal fro community-based res	m home or a idential setting is essential			
	adolescent's catchme (g) The PRTF shall be the following; Joint Co of Healthcare Organiz	coordinate with other sies within the child or ent area. The accredited through one of commission on Accreditation contacts are the commission on			
	Accreditation of Reha	bilitation Facilities; the			

Division of Health Service Regulation

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STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
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		MHL047-158	B. WING		01/05/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CANYON	HILLS TREATMENT FAC	CILITY	DEEN ROAD		
	Т	RAEFORI	D, NC 28376		
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V 314	Continued From page	e 4	V 314		
	Council on. Accredita accrediting bodies as Medical Assistance C Psychiatric Residenti including subsequent A copy of Clinical Pol at no cost from the D	tion or other national set forth in the Division of Clinical Policy Number 8D-1,			
	facility (1) failed to co agencies within the c catchment area affec clients (Former Client supervision and spec 24-hour basis for one (FC#3). The findings	ew and interviews, the ordinate with individuals and hild or adolescent's ting one of three audited t #2) and (2) failed to provide ialized interventions on a e of three audited clients are:			
	-Admission date: 1/15 -Diagnoses of Attention Disorder, Predominat	on Deficit Hyperactivity tely Hyperactive/Impulsive, iptive Mood Dysregulation tt Disorder.			
	Family Treatment Me -6/15/20 - Psychologi -7/27/20 - "psycholog -8/5/20 - "psychologic	cal testing referral." lical testing. cal evaluation - attending ents. 2 sessions completed			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
CANYON	HILLS TREATMENT FAC	:II ITY 769 ABEI	RDEEN ROAD		
		RAEFOR	D, NC 28376		
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V 314	Continued From page	e 5	V 314		
	Summary dated 2/27, -6/15/20 - [FC#2] can [Nurse Practitioner] repsychological testing -Comments: initial evtesting with [Doctor]. 7/27/20." Additional comments at 10:00 a.m. Please completion of assess Review on 12/19/20 on Notes on Psychological -6/15/20 at 9:17 a.m. appointment in [local evaluation" -6/15/20 at 7:32 p.m. testing appointment." -7/27/20 - [FC#2] has for psychological test -7/27/20 at 8:15 p.m. from appointment F(8/17/20 at 10:00 a.m. to be completed and -8/17/20 at 7:25 a.m. assessment" -8/17/20 at 5:05 p.m. facility with staff from Review on 12/19/20 or report dated August 2-Dates of evaluation: 17, 2020Background Informal information is a brief psychological testing interview and availability in the staff of the psychological testing interview and availability in the staff of the psychological testing interview and availability in the staff of the psychological testing interview and availability in the psychological testing interview and availability in the psychological testing interview and availability and psychological testing interview and psychological testing interview.	ne in for an evaluation eferred [FC#2] for to be scheduled later" aluation for psychological [Doctor] signed and dated : "next appointment 8/17/20 e assist [FC#2] with ment (attached)." of the Registered Nurse cal Testing revealed:			

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
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				DEFICIENCY)	
V 314	Cantinual Francisco	- 6	V 314		
V 314	Continued From page	9 0	V 314		
	background on IFC#2	2] please refer to [FC#2's]			
	medical chart which o				
		rovider [FC#2] has seen at			
	the [psychological ce				
	the [psychological cel	nterj.			
) :#- FO#0!			
) with FC#2's guardian			
	revealed:				
		ired to transport FC#2 to the			
	office for psychologic	· ·			
	-FC#2 went about 3x	times.			
	-She met FC#2 there				
	-FC#2was supposed	to do a few sessions.			
	-First session was inf	ormation session about			
	FC#2.				
		a 3 hour visit with FC#2			
	being observed in are				
	questioning behaviors				
	_	were sent home for a			
	questionnaire packet.				
		nad one and the facility was			
	supposed to have on				
	-One was for the ther	•			
	representative like a t				
	·	rtion and returned it during			
	the 3rd visit.				
		posed to bring their paper			
	work back during the	3rd visit.			
	-The facility did not be	ring back the paperwork.			
		work to the driver to give to			
	the facility manager.	-			
		did not bring their portion			
	back in.	3 1			
		Worker and informed her			
	that the paperwork wa				
		eported that she did not get			
		sported that she did not yet			
	paperwork.				
		ed out to the psychological			
	agency to see if she				
	-The psychological a	gency would not be able to			

send packet directly.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL047-158 B. WING		C 01/05/2021		
NAME OF PROVIDER OR SUPPLIER CANYON HILLS TREATMENT FA	STREET AD 769 ABER	DORESS, CITY, STARDEEN ROAD D, NC 28376	TE, ZIP CODE		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE	
the packet to her to -They were about a time to get resultsShe asked the doct agency for the other -She reported the de could use assessme -She reported the de previous assessmer same behaviorShe provided the a previous placement coming directly from -She did not feel the valid rundown on FO -FC#2 lived with her -She tried to give be -The doctor needed himselfShe felt the doctor FC#2She directly hander -She gave the packer supposed to give it to facility. Interview on 12/22/2 revealed: -FC#2 mom reporte the transport teamWhen the transport they were supposed -The documents we transport folderShe informed FC#2 not in the folder.	agency would have to send give to the social worker. week away and not enough for at the psychological options. Octor suggested that she ent from previous placement. Octor said he could the not due to the FC#2 having the essessment from current and put it was information in therapist. Information provided was a compared to the form the paperwork to the driver. The paperwork to the facility of the gave the document to the paperwork to the facility of the give to the nurse. The papers were	V 314			

Division of Health Service Regulation

-She looked for the paper work a couple of days

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
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		MHL047-158	B. WING		01/05/2021	
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(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)	
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				DEFICIENCY)		
V 314	Continued From page	2 8	V 314			
V 314	Continued From page	, 0	1014			
	later.					
	-She did not speak to	Registered Nurse.				
	-Registered Nurse wo	_				
	•	s were in the nursing station.				
	•	osychological agency and				
	due to Covid hours va					
	_	vith the psychologist but did				
	not receive a return p					
	-FC#2 was the first cl	•				
	psychological agency					
	-The psychological ag	gency they usually used had				
	a long waiting list.					
	-The care coordinator	brought up this				
	psychological agency	• .				
		gency never returned her				
	call.	goney never retained ner				
		FC#2 had autism which				
	was other reason for	the testing.				
	Interview on 12/22/20	with the Director of Nursing				
		with the Director of Nursing				
	revealed:					
		rote the note on 7/27/20.				
		nat the FN #11 could have				
	done with the paperw	ork.				
	 Typically, the paperw 	vork was for the teacher and				
	social worker to comp	olete.				
	-The nursing departm	ent completed the transport				
	summary.	•				
		e transport sheet provided				
	comments.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
		opportunity to complete				
	comments.	opportunity to complete				
		was completed and				
	-The transport sheet					
	transport staff had a f					
		have 2 transport staff.				
		id not know what happened				
	to the paper work.					
	Interview on 1/4/21 w	ith the Clinical Director				

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revealed:

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Division of	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
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		MHL047-158	B. WING		01/05	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
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CANYON	HILLS TREATMENT FAC	CILITY				
		RAEFUR	D, NC 28376			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
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V 314	Continued From page	e 9	V 314			
	Th					
		osychological agency and				
		obtain the paperwork.				
	,	ceived the paperwork but				
	not in time to complet	te the psychological				
	evaluation.					
		efforts in trying to obtain the				
	paperwork during the	child/family treatment team				
	meeting.					
	-Confirmed there was	s a travel folder and FC#2's				
	document was not in	the folder.				
	2. Review on 12/21/2	0 of FC#3's record revealed:				
	-Admission date: 3/1	1/20.				
	-Diagnoses of Attention	on Deficit Hyperactivity				
		sorder, Moderate and				
	Disruptive Mood Dysi					
	-Discharged date: 11/	•				
	Biodriai god dato. 117	, 6, 2 6 .				
	Interview on 12/16/20) with FC#3's Guardian				
	revealed:	Will I One o Guardian				
		some of the other clients				
	was watching pornog					
	electronic devices.	rted some of clients had				
		the only white kid				
	-She said FC#3 was	the only write kid.				
	Interview on 12/22/20) with Social Worker #8				
		Willi Social Worker #6				
	revealed:	a alda ta davvala ad man O				
		e able to download mp3				
	players	16 11 6				
		re removed from the floor.				
		nts know they could not send				
	MP3 players that was					
		d it had to be a specific type.				
		d August or September				
	2020.					
	-FC#3 did not have a	MP3 player.				
	-FC#3 heard about th	ne incident and did not				
	witness it		1			

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-The MP3 player downloaded a picture.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE. ZIP CODE		
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V 314	Continued From page	e 10	V 314			
	revealed: -The MP3 players we allowed flat screenMP3 players were not facilityThere was pictures of foundThere was no active -The MP3 player was searchThe MP3 player was -They no longer have facility.	found during contraband				
V 364	Quality Improvement -They would start che -Clinical Department client leaves the facili -Clinical Department nursing meetings to e -They would add ano monitor any forms red G.S. 122C- 62 Addit	ecking transportation folders. would check folders when ity and return. would start participating in ensure coordination of care. ther form for clinical staff to	V 364			
	122C-51 through G.S who is receiving treat 24-hour facility keeps (1) Send and receiv	e rights enumerated in G.S. S. 122C-61, each adult client tment or habilitation in a				

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DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
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NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		769 ARER	DEEN ROAD			
CANYON	HILLS TREATMENT FAC	ILITY	, NC 28376			
			, NC 20376			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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V 364	Continued From page	e 11	V 364			
	assistance when need	ooografi				
	assistance when nece					
		sult with, at his own expense				
		facility, legal counsel, private				
	physicians, and privat					
	•	lities, or substance abuse				
	professionals of his cl					
	• •	sult with a client advocate if				
	there is a client advoc					
		n this subsection may not be				
	•	ty and each adult client may				
		at all reasonable times.				
	. ,	ed in subsections (e) and (h)				
	of this section, each a	adult client who is receiving				
	treatment or habilitation	on in a 24-hour facility at all				
	times keeps the right	to:				
	(1) Make and receive	e confidential telephone				
	calls. All long distance	e calls shall be paid for by				
	the client at the time of	of making the call or made				
	collect to the receiving	g party;				
	(2) Receive visitors I	between the hours of 8:00				
	a.m. and 9:00 p.m. fo	r a period of at least six				
		s of which shall be after 6:00				
		shall not take precedence				
	over therapies;	·				
	•	nd meet under appropriate				
	` '	iduals of his own choice				
	upon the consent of the					
	· · · · · ·	de the custody of the facility				
	unless:	as and casteay or are tasking				
		ceedings were initiated as				
		's being charged with a				
		ng a crime involving an				
	assault with a deadly	•				
		d not guilty by reason of				
	insanity or incapable					
	-					
		oluntarily admitted or				
		ity while under order of				
	commitment to a corre					
	Division of Adult Corre	ection of the Department of	1			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		D MINO		С		
MHL047-158		B. WING		01/05/2021		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
769 ABERDEEN ROAD						
CANYON HILLS TREATMENT FACILITY 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 364	Continued From page	e 12	V 364			
	Public Safety; or	as hold to determine conseit.				
	c. The client is bein to proceed pursuant t	ig held to determine capacity				
		pressly authorize visits				
		by the existence of the				
	conditions prescribed	-				
		daily and have access to				
		ent for physical exercise				
	several times a week					
	(6) Except as prohib	ited by law, keep and use				
	personal clothing and	l possessions, unless the				
	client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;					
	(7) Participate in reli	-				
		a reasonable sum of his				
	own money;	Barrara contact allocations				
	` '	license, unless otherwise				
	prohibited by Chapter 20 of the General Statutes; and (10) Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a					
	•					
	proper adult supervisi	ie right to have access to				
		nor's status as a developing				
	individual, the minor s	. 0				
		le him to mature physically,				
	emotionally, intellectu					
	•	of the physical, emotional,				
	and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with					
		e minor pursuant to this Part.				
	The facility shall also, where practical, make					
		ensure that each minor				
client receives treatment apart and separate from						

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	of Health Service Regu		<u> </u>		ı	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
				С		
MHL047-158		B. WING		01/05/	/2021	
NAME OF D	ROVIDER OR SUPPLIER	OTDEET A	DDRESS, CITY, STAT	E ZIR CODE	-	
NAME OF PI	ROVIDER OR SUPPLIER			E, ZIP CODE		
CANYON HILLS TREATMENT FACILITY 769 ABERDEEN ROAD						
	Г	RAEFOR	RD, NC 28376			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
V 364	Continued From page	- 12	V 364			
V 304	Continued From page	e 13	V 304			
	adult clients unless th	ne treatment needs of the				
	minor client dictate of					
	Each minor client who	o is receiving treatment or				
		-hour facility has the right to:				
		nd consult with his parents or				
		cy or individual having legal				
	custody of him;					
	` '	sult with, at his own expense				
		esponsible person and at no				
	cost to the facility, legal counsel, private					
	physicians, private mental health, developmental					
	· ·	nce abuse professionals, of				
		s or his legally responsible person's choice; and				
	(3) Contact and consult with a client advocate, if there is a client advocate.					
		n this subsection may not be				
		ty and each minor client				
	_	ights at all reasonable times.				
		led in subsections (e) and (h)				
		minor client who is receiving				
		on in a 24-hour facility has				
	the right to:	,				
	(1) Make and receiv	e telephone calls. All long				
	distance calls shall be	e paid for by the client at the				
	time of making the ca	all or made collect to the				
	receiving party;					
		e mail and have access to				
		tage, and staff assistance				
	when necessary;					
		te supervision, receive				
		nours of 8:00 a.m. and 9:00				
	-	t least six hours daily, two				
		be after 6:00 p.m.; however				
	_	precedence over school or				
	therapies;					
		education and vocational				
	training in accordance with federal and State law; (5) Be out of doors daily and participate in play,					
	recreation, and physical exercise on a regular		1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED				
		-		_				
				C				
MHL047-158		B. WING		01/05/2021				
NAME OF D	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
NAME OF F	NOVIDER OR SUFFLIER			KIE, ZIF GODE				
CANYON	CANYON HILLS TREATMENT FACILITY							
		RAEFOR	RD, NC 28376					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)			
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE			
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE			
				DEFICIENCY)				
V 364	Continued From page	1/1	V 364					
٠ ٥٥٠	Continued From page	, I T	• • • •					
	basis in accordance v	with his needs;						
	(6) Except as prohib	ited by law, keep and use						
	personal clothing and							
	'	on, unless the client is being						
		pacity to proceed pursuant to						
	G.S. 15A-1002;	sacity to proceed paredam to						
	(7) Participate in reli	gious worship:						
		ndividual storage space for						
	\ ,	ŭ ,						
	the safekeeping of pe							
	(9) Have access to and spend a reasonable sum							
	of his own money; an							
	(10) Retain a driver's license, unless otherwise							
		r 20 of the General Statutes.						
	. ,	ated in subsections (b) or (d)						
	_	e limited or restricted except						
	by the qualified profe	ssional responsible for the						
	formulation of the clie	ent's treatment or habilitation						
	plan. A written statem	nent shall be placed in the						
	client's record that ind	dicates the detailed reason						
	for the restriction. The	e restriction shall be						
	reasonable and relate	ed to the client's treatment or						
	habilitation needs. A restriction is effective for a							
	period not to exceed 30 days. An evaluation of							
	each restriction shall be conducted by the							
	qualified professional at least every seven days.							
	at which time the rest	riction may be removed.						
	Each evaluation of a							
		ent's record. Restrictions on						
	rights may be renewed only by a written							
	statement entered by the qualified professional in							
		it states the reason for the						
	renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal							
		ts, an individual designated						
		on the consent of the client,						
		riction and of the reason for						
		nor client or an incompetent						
	adult client, the legally responsible person shall							

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			
MHL047-158		B. WING		C 01/05/2021		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CANYON	HILLS TREATMENT FAC	ILITY	DEEN 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
V 364	Continued From page	e 15	V 364			
	be notified of each insor renewal of a restrict reason for it. Notificat individual or legally re	stance of an initial restriction ction of rights and of the				
	This Rule is not met as evidenced by: Based on record review and interviews, the facility management failed to ensure each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to communicate and consult with parents or guardian or the agency individual having legal custody for one of threee audited client (#1). The findings are:					
	Disorder, Combined F Disorder, Childhood, Child Sexual Abuse, C Child Non-parental So					
	revealed: -Virtual visits once a rattendanceShe did not have one without being monitor	with Client #1's Parent month and staff was in e-on-one conversation red. ith the Clinical Director				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL047-158	B. WING			C / 05/2021	
NAME OF PRO	VIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
CANYON HILLS TREATMENT FACILITY 769 ABERDEEN ROAD							
			RD, 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
ri n 	nanager or staff or so "We can't trust the cl Client's can't keep th Zoom meetings was Three therapist share They would be working privacy. Interview on 1/5/21 we Quality Improvement Client's would use the irtual/zoom calls with The door for the control	metings Its either a facility ocial worker. ients to stay in the room." eir hands off of anything. on the computer. e one office space. ng on locating space for ith the Clinical Director and Director revealed: e conference room for a guardians and providers. ference room was a fire	V 364				

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