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CANYON HILLS TREATMENT FACILITY	769 ABERDEEN ROAD RAEFORD, NC 28376

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V 000	INITIAL COMMENTS An Annual and Complaint survey was completed on May 11, 2021. One complaint was substantiated (Intake #NC00175843) and one complaint was unsubstantiated (Intake #NC00176138). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
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 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	V 314		

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V 314	Continued From page 1 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 interview and record review, the facility failed to provide required supervision and specialized interventions to ensure the safety of clients on a 24-hour basis affecting 3 of 3 audited clients (#1 #2 #3). The findings are: Review on 5/4/21 of Client #1's record revealed the following information: -- A 16-year-old male. -- Admitted to the facility on 4/14/21. -- Diagnoses include Disruptive Mood Dysregulation Disorder, ADHD (Attention Deficit Hyperactivity Disorder), PTSD (Post Traumatic Stress Disorder), Unspecified Mood Disorder, Crohn's Disease and Chronic Anemia. -- Documentation that he was seen in the emergency room on 5/4/21 "May need light activities secondary to concussion." "Reason for	V 314		

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visit: head injury. Dx (diagnosis): Closed head injury. Make apt (appointment) with primary care provider asap (as soon as possible) for a visit in 1 week." Treatment provided: "CT (CAT Scan) of head without contrast."

Review on 5/5/21 of Client #2's record revealed the following information:
-- A 17-year-old male.
-- Admitted to the facility on 10/22/20.
-- Diagnoses include Conduct Disorder, ADHD, and Cannabis Use Disorder.
-- Is currently on probation.

Interview on 5/4/21 at 9:15 am with both the Clinical Director (CD) and one of the Social Workers (SW) revealed the following information:
-- Early that morning (around 1:00 am on 5/4/21) an incident occurred on one of the 2 client bedroom hallways in the facility.
-- On the third shift (11:00 pm to 7:00 am), two clients (Client #2 and Client #3) entered Client #1's bedroom, and while he was asleep, began punching and kicking him.
-- It is believed that several other clients were aware of the plan to harm Client #1.
-- A couple of these clients probably created a diversion on the hallway, and when no staff were able to observe them, Client #2 and Client #3 snuck into Client #1's room.
-- That hallway is on lock down from that incident.
-- The clients are currently doing their schoolwork in their rooms while on lockdown.

Review on 5/7/21 of the North Carolina Incident Response Improvement System (IRIS) revealed no incident report had been submitted regarding this event.

Review on 5/5/21 of the facilities internal Level I

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V 314	Continued From page 3 incident reports revealed no documentation regarding this event. Interview on 5/6/21 with Client #1 revealed the following information: -- We are on lockdown now because "older kids jumped me in my sleep, [Client #2] and [Client #3]." -- "They were bullying me for 3 weeks. They kicked me in the head, they knocked me out." -- "I didn't call for staff. [Staff #2] was yelling (for help) and [Staff #1] came in and got them off of me." -- "I got a concussion." -- "They didn't apologize." -- "I have headaches and migraines, they are constant. Tylenol doesn't help but it makes it bearable." -- "This is my second day on this side (the other client bedroom hallway). I'm not on sleeping meds (medications) anymore. I won't take them." -- "I sleep with one eye open (now)." Interview on 5/7/21 with the Facility Manager (FM) revealed the following information regarding the incident that occurred on 5/4/21 with Clients #1, #2 and #3: -- There are always 3 staff on the hallway during the third shift. One staff sits at each end of the hall and the other staff watches the middle of the hall. -- It happened very early on Tuesday morning and he was called to come back to the facility to assist. -- He got there about 1:00 or 1:30 am. -- He was told the following: the team leader gave the clients on the hallway directives to stay in their rooms. One of the clients came out into the hallway to ask for a drink of water, "and that must have been when the 2 clients snuck into [Client	V 314		

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#1's] room."
-- The FM acknowledged that he had been told that the team leader had left the unit to start the laundry while the second staff stepped off of the hallway to get one of the clients a drink of water. This left only one staff supervising all of the clients for a short while.
-- All 3 of the clients may have been having conversation(s) about gang involvement.
-- Client #1 was taken to the emergency room for evaluation.
-- Client #1 had a scratch on his forehead, but was not bleeding.
-- "While Client #1 was gone we moved his room to the other hallway so that he wouldn't be around his attackers."
-- "We moved Client #2 and Client #3's rooms to the opposite ends of the hallway to keep them apart."
-- He pulled all of the boys out of their rooms one at a time to talk to them and he was not able to gather any further information from them.
-- He didn't have access to be able to watch the video recorded that night.

Interview on 5/6/21 with Staff #1 revealed the following information;
-- He was the team leader on the night shift on 5/4/21 and worked with two other staff.
-- All the clients were awake when he came on to the hallway around midnight.
-- Sometimes the clients have a difficult time getting to sleep at night, or they aren't tired because they have been napping during the day.
-- He gave them all the directives on the hallway, "I said don't come out of your rooms."
-- A couple of minutes later I went (to the front of the building) to "start the laundry."
-- All the laundry gets done on the third shift and staff rotate the laundry duty between each staff.

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V 314	Continued From page 5 -- Staff #2 and #3 (both female staff) were at either end of the hallway. -- A client asked Staff #3 for a drink of water. -- She left the hallway for a few moments to get a cup and some water for the client from in the community area. -- "I think there was another client out of his room asking to go to the bathroom." -- He confirmed that this left only one staff (Staff #2) on the floor of the hallway. -- He got a call on the walkie-talkie to come back to the unit. -- The clients were back in their room when he got back to the hallway. -- Staff got Client #1 ready and he was transported to the emergency room. -- He stated that he didn't watch the video recording from that night. Interview on 5/10/21 with Staff #3 revealed the following information; -- The team leader gave the consumers their directives and then went to start the laundry. -- Two clients came out of their rooms asking for water. -- She went to the recreation room to get cups and a drink of water for them. -- There are 2 doors between the hallway and the recreation room. One door was open (to the recreation room) and the other door (going to the hallway) was closed. -- While she was gone the other two consumers must have snuck into Client #1's room. -- When she came back (on the hallway with the water) the team lead was there. -- The other 2 clients were already back in their rooms. -- The team leader pulled the clients out of their rooms to talk to them. -- Then she was sent to the other hallway to	V 314		

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check to make sure the other consumers were asleep.
-- After this happened "I was a little bit scared."

Interview on 5/6/21 with Client #2 revealed the following information;
-- "Everyone is on lockdown."
-- "I jumped somebody while they were sleeping."
**NOTE: This client did not want to answer any further questions regarding this incident, and would not admit to another client helping him with the assault on Client #1.

Interview on 5/7/21 with Client #3 revealed the following information;
-- "He (Client #1) was telling staff that we were picking on him, then we went on 'Bullying Week' (as a punishment)."
-- "Then he was up staff's a*s and getting us in more trouble."
-- "I never even talked to him."
-- "I decided I was going to hurt him."
-- "I went into his room alone, punched him about 4 times, then I left the room."
-- "I wasn't in there (Client #1's room) with nobody (other clients)."
-- "Staff on the hallway was getting somebody water or something."

Interview on 5/6/21 with the CD revealed the following information;
-- There is a video camera recording all actions on the hallway at all times.
-- The video camera did not record within the client bedrooms.
-- Unless within a 24 hour period, someone requests to view the recording, the camera loops over and begins to re-record every 24 hours.
-- There is no video recorded information documenting the events that took place the

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V 314	Continued From page 7 morning of 5/4/21 available to view. Review on 5/11/21 of the Plan of Protection dated 5/11/21 written by the QI (Quality Improvement) Director revealed the following information; "What immediate actions will the facility take to ensure the safety of the consumers in your care? Canyon Hills Treatment Facility moved the child to the other side, to prevent further possible harm. Canyon Hills Treatment Facility ensured that the two perpetrates and no longer allowed to interact one-on-one with each other. Canyon Hills Treatment Facility reported the two perpetrates actions to their probation officers, police and guardians. Describe your plans to make sure the above happens: Canyon Hills Treatment Facility will ensure that staff monitors ongoing conversations between residents. Canyon Hills Treatment Facility will inform staff to delay task until at least 75% of the residents are asleep." Clients between the ages of 7 and 17 with diagnoses including Disruptive Mood Dysregulation Disorder, ADHD, PTSD, Conduct Disorder, Oppositional Defiant Disorder, Adjustment Disorder, Anxiety Disorder, Mood Disorders and Substance Use Disorders are provided services and supervision at the facility. The client histories include displaying self-destructive behaviors such as physical assault, damage to property, harm to themselves and others, manipulation, and lying. During the time when staff is to be providing 24-hour supervision, the supervision of an entire bedroom hallway (of 11 clients) was reduced from the required ratio of 3 staff, to a single staff for a	V 314		

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V 314	Continued From page 8 short period of time. During this period of time 2 clients (#2 & #3) entered Client #1's bedroom and assaulted him. This assault resulted in Client #1 being seriously injured and he was transported to an emergency room where he was diagnosed with a concussion to his head. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $3000.00 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 compliance beyond the 23rd day.	V 314		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B,	V 366		

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V 366	Continued From page 9 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact	V 366		

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V 366	Continued From page 10 within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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V 366	Continued From page 11 This Rule is not met as evidenced by: Based on interview and record review, the facility management failed to assure all Level 2 incidents were reported with responses documented to the LME (Local Management Entity) and the North Carolina Disability Rights (NCDR) office. The findings are: Review on 5/4/21 of the North Carolina Incident Response Improvement System (IRIS) revealed the following information; -- During the year 2021 (up until 5/4/21), 31 incident reports were documented and submitted into the system. -- During the year 2020, 88 incident reports were documented and submitted into the system. -- Nothing on any of the above reports indicated that the information obtained was provided to the LME or NCDR. Interview on 5/6/21 with the Clinical Director revealed the following information; -- It is the Nurse's responsibility to submit IRIS reports. -- She thinks reports were sent to the NCDR last year (2020) in July. -- Those reports would have been for the year 2019. -- She is not sure why IRIS reports were not being forwarded to NCDR or the LMEs. -- She would make sure this information was provided to both of these entities from here forward.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367		

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V 367	Continued From page 12 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 unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:	V 367		

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V 367	Continued From page 13 (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 meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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 _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 14	V 367		

This Rule is not met as evidenced by:
Based on interview and record review, the facility management failed to assure all Level 2 incidents were reported and failed to notify the LME (Local Management Entity) and the North Carolina Disability Rights (NCDR) office within 72 hours of becoming aware of the incident. The findings are:

Review on 5/4/21 of the North Carolina Incident Response Improvement System (IRIS) revealed the following information;
-- During the year 2021 (up until 5/4/21), 31 incident reports were documented and submitted into the system.
-- During the year 2020, 88 incident reports were documented and submitted into the system.
-- Nothing on any of the above reports indicated that the information obtained was provided to the LME or NCDR.

Interview on 5/6/21 with the Clinical Director revealed the following information;
-- It is the Nurse's responsibility to submit IRIS reports.
-- She thinks reports were sent to the NCDR last year (2020) in July.
-- Those reports would have been for the year 2019.
-- She is not sure why IRIS reports were not being forwarded to NCDR or the LMEs.
-- She would make sure this information was provided to both of these entities from here

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V 367	Continued From page 15 forward.	V 367		