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V 000	INITIAL COMMENTS An annual, follow up, and complaint survey was completed on August 9, 2021. The complaint was substantiated (intake #NC177857). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment Center for Children or Adolescents.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying,	V 108		

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V 108	Continued From page 1 reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure staff were trained to meet the needs of the clients for 33 of 36 audited current staff (the registered nurse (RN) and Staff #1-32). The facility also failed to ensure at least one staff member trained in basic first aid and cardiopulmonary resuscitation (CPR) was available at all times while clients were present. The findings are: Review on 6/28/21 of the RN's record revealed: -A hire date of 5/22/19. -CPR/First Aid certification which expired 2/12/21. -There was no documentation of CPR certification renewal until 3/20/21. Review on 6/28/21 of Staff #1's record revealed: -A hire date of 9/14/20. -There was no documentation of client specific training. Review on 6/28/21 of Staff #2's record revealed: -A hire date of 6/15/20. -There was no documentation of client specific training. Review on 6/28/21 of Staff #3's record revealed: -A hire date of 11/29/18. -There was no documentation of CPR/First Aid certification, or client specific training.	V 108		

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V 108	Continued From page 2 Review on 6/28/21 of Staff #4's record revealed: -A hire date of 3/3/19. -There was no documentation of client specific training. Review on 6/28/21 of Staff #5's record revealed; -A hire date of 7/5/19. -There was no documentation of client specific training. Review on 6/28/21 of Staff #6's record revealed: -A hire date of 6/21/21. -There was no documentation of CPR/First Aid certification, or client specific training. Review on 6/28/21 of Staff #7's record revealed: -A hire date of 1/28/19. -The online portion of CPR/First Aid training had been completed on 4/11/21. -There was no evidence a hands-on skills session had been completed with a CPR instructor. -There was no documentation of client specific training. Review on 6/28/21 of Staff #8's record revealed: -A hire date of 2/1/21. -There was no documentation of CPR/First Aid certification, or client specific training. Review on 6/28/21 of Staff #9's record revealed: -A hire date of 6/7/21. -There was no documentation of CPR/First Aid certification, or client specific training. Review on 6/28/21 of Staff #10's record revealed: -A hire date of 5/19/21. -There was no documentation of CPR/First Aid certification, or client specific training.	V 108		

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V 108	Continued From page 3 Review on 6/28/21 of Staff #11's record revealed: -A hire date of 4/13/20. -The online portion of CPR/First Aid training had been completed on 3/1/21. -There was no evidence a hands-on skills session had been completed with a CPR instructor. -There was no documentation of client specific training. Review on 6/28/21 of Staff #12's record revealed: -A hire date of 6/6/19. -There was no documentation of client specific training. Review on 6/28/21 of Staff #13's record revealed: -A hire date of 9/28/20. -CPR/First Aid certification which expired 6/12/21. -There was no documentation of client specific training. Review on 6/28/21 of Staff #14's record revealed: -A hire date of 3/2/20. -The online portion of CPR/First Aid training had been completed on 4/11/20. -There was no evidence a hands-on skills session had been completed with a CPR instructor. -There was no documentation of client specific training. Review on 6/28/21 of Staff #15's record revealed: -A hire date of 8/31/20. -There was no documentation of CPR/First Aid certification, or client specific training. Review on 6/28/21 of Staff #16's record revealed: -A hire date of 2/1/21. -There was no documentation of client specific	V 108		

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V 108	Continued From page 4 training. Review on 6/28/21 of Staff #17's record revealed: -A hire date of 5/26/21. -There was no documentation of client specific training. Review on 6/28/21 of Staff #18's record revealed: -A hire date of 9/28/20. -There was no documentation of client specific training. Review on 6/28/21 of Staff #19's record revealed: -A hire date of 6/14/21. -There was no documentation of CPR/First Aid certification, or client specific training. Review on 6/28/21 of Staff #20's record revealed: -A hire date of 3/22/21. -There was no documentation of CPR/First Aid certification, or client specific training. Review on 6/28/21 of Staff #21's record revealed: -A hire date of 9/28/20. -The online portion of CPR/First Aid training had been completed on 5/4/21. -There was no evidence a hands-on skills session had been completed with a CPR instructor. -There was no documentation of client specific training. Review on 6/28/21 of Staff #22's record revealed: -A hire date of 6/16/20. -There was no documentation of CPR/First Aid certification, or client specific training. Review on 6/28/21 of Staff #23's record revealed: -A hire date of 3/1/21. -There was no documentation of client specific	V 108		

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V 108	Continued From page 5 training. Review on 6/28/21 of Staff #24's record revealed: -A hire date of 4/5/21. -There was no documentation of CPR/First Aid certification, or client specific training. Review on 6/28/21 of Staff #25's record revealed: -A hire date of 3/1/18. -CPR/First Aid certification which expired 12/31/2018. -There was no documentation of CPR/First Aid certification renewal, or client specific training. Review on 6/28/21 of Staff #26's record revealed: -A hire date of 8/31/20. -There was no documentation of client specific training. Review on 6/28/21 of Staff #27's record revealed: -A hire date of 7/27/20. -There was no documentation of CPR/First Aid certification, or client specific training. Review on 6/28/21 of Staff #28's record revealed: -A hire date of 4/12/18. -CPR/First Aid certification expired 1/2/20. -The online portion of CPR/First Aid training was renewed on 4/18/21. -There was no evidence a hands-on skills session had been completed with a CPR instructor. -There was no documentation of client specific training. Review on 6/28/21 of Staff #29's record revealed: -A hire date of 3/16/20. -There was no documentation of client specific training.	V 108		

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Review on 6/28/21 of Staff #30's record revealed:
-A hire date of 2/16/20.
-There was no documentation of client specific training.

Review on 6/28/21 of Staff #31's record revealed:
-A hire date of 6/2/21.
-There was no documentation of CPR/First Aid certification, or client specific training.

Review on 6/28/21 of Staff #32's record revealed:
-A hire date of 10/12/20.
-There was no documentation of CPR/First Aid certification, or client specific training.

Review on 6/29/21 of the overnight schedule for facility staff from 4/14/21 through 7/3/21 revealed:
-Only 2 of the staff on the overnight schedule (Staff #2 and Staff #17) were certified in CPR.
-There were 46 overnight shifts in which a CPR certified staff member was not on the schedule as follows: 4/14/21 through 5/4/21; 5/6/21 through 5/9/21; 5/13/21 through 5/16/21; 5/19/21 through 5/26/21; 5/28/21; 6/1/21; 6/3/21 through 6/4/21; 6/9/21 through 6/11/21; 6/16/21 through 6/18/21 and 6/23/21 through 6/25/21.
-There were no CPR trained staff on the schedule for the overnight shifts of 6/30/21, 7/1/21 and 7/2/21.

Interview on 7/9/21 with the Executive Director (ED) revealed:
-The Human Resource (HR) Operations Manager, the Program Director, the Clinical Director and the Executive Director shared the responsibility of ensuring that all staff were adequately trained.
-The process for auditing staff records was changed during the COVID 19 pandemic.
-Records were audited virtually and "items were

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V 108	Continued From page 7 missed." -He stated, "So as the Executive Director, all responsibility rolls up to me and I personally take accountability for not recognizing that our audit system was not adequate." -A new HR Operations Manager was recently hired and new processes would be put in place to make sure files are appropriately maintained. This deficiency is cross referenced into 10A NCAC 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging 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. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based	V 109		

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V 109	Continued From page 8 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, 4 of 4 audited qualified professionals (Therapist #1, Therapist #2, the Registered Nurse (RN) and the Executive Director (ED)) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: Refer to tag V112, V118 and V179 for additional information. The following are examples of how Therapist #1 failed to demonstrate competency: -It was the responsibility of the Primary Therapist to implement and update client treatment plans. -Therapist #1 was the Primary Therapist for Client #2, Former Client (FC) #6 and FC #7 . -Client #2's treatment plan did not address his depression, self-harm, or high risk sexual behaviors. -FC #6 had goals related to impulse control and compulsions, trauma, learning disability, attention-deficit hyperactivity disorder (ADHD)	V 109		

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and parent child relationship which were implemented into his treatment plan on 6/25/21.
FC #6 was removed from the facility by his legal guardian on 9/25/20 against medical advice (AMA). All of FC #6's goals were changed to "resolved" even though he had not completed the program.
-FC #7's treatment plan did not address his "risky sexual conduct."
-FC #7 had goals related to parent child relationship, depression/suicidal ideation, substance abuse, ADHD, anxiety and trauma which were implemented onto his treatment plan on 2/23/21. FC #7 was removed from the facility on 3/24/21 related to inappropriate sexual activity with an 18 year old client. All of FC #7's goals were changed to "resolved" on 3/24/21 even though he had not completed the program.
-When FC #7 disclosed that he had sexual activity with the 18 year old client, he was subjected to three separate interviews. The first with his Primary Therapist, the second with his Primary Therapist and a phone call with his parents and the third was with his Primary Therapist and another staff member.

Interview on 7/9/21 with Therapist #1 revealed:
-When asked if multiple interviews with FC #7 was therapeutic, she replied " ...to make sure that we crossed all our t's and dotted all our i's it was necessary. Maybe not ideal, but it was necessary in that situation."

The following are examples of how Therapist #2 failed to demonstrate competency:
-It was the responsibility of the Primary Therapist to implement and update client treatment plans.
-Therapist #2 was the Primary Therapist for Client #5 and FC #10.
-Client #5's treatment plan did not address his

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self-harm behaviors.
-FC #10's treatment plan had goals and strategies with a start date of 4/17/20 and an end of 4/17/21, yet the same plan was utilized through 6/14/21 when FC #10 was discharged.

The following are examples of how the RN failed to demonstrate competency:
-The RN's job description required CPR certification, yet the RN's CPR certification expired on 2/12/21 and was not renewed until 3/30/21.
-The RN was responsible for training facility staff in medication administration.
-The RN failed to recognize that there was no documentation of medication administration training for Staff #11 even though he was administering medications to clients.
-The RN failed to maintain medication administration training records and admitted that she threw them away whenever a staff member resigned.
-FC #9 was not taken to the emergency department for 5 1/2 hours after sustaining a head laceration due to the RN's delay of trying to obtain parental consent.
-FC #10 fractured his collar bone and the RN delayed FC#10's medical evaluation and treatment for 6 days.

The following are examples of how the ED failed to demonstrate competency:
-The ED was the direct supervisor of the RN.
-The ED was aware of the delay in FC #10's medical treatment and believed FC #10's parents suggested waiting.
-FC #10 had a signed Power of Attorney upon admission which gave Equinox permissiont o obtain medical treatment when necessary.
-He was aware that clients were engaging in

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V 109	Continued From page 11 sexual behaviors and failed to assess for increased supervison, staff training, or other interventions. -He had not understood that the Calm Room could not be utilized until it was approved by the Division of Health Service Regulation (DHSR) Construction Section. -He gave DHSR surveyors documentation which showed he was aware that adults could not share a bedroom with minors, yet the facility continued to have 18 year old clients share a room with minors. Review on 7/8/21 of the ED's Job Description revealed: -Job duties and responsibilities included: -"Reviews incident reports to assess for trends and correct risk factors." -"Oversees Equinox RTC's compliance with North Carolina State Licensing requirements." This deficiency is cross referenced into 10A NCAC 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
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	V 112		

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V 112	Continued From page 12 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement treatment strategies for 2 of 5 audited current clients (Clients #2, #5) and 4 of 5 audited former clients (FC #6, FC #7, FC #8, and FC #10). The findings are: Review on 6/28/21 of Client #2's record revealed: -date of admission: 06/04/2020 -diagnoses: Major Depressive Disorder (D/O) recurrent, moderate, Adjustment D/O, Generalized Anxiety Disorder, Oppositional Defiant Disorder (ODD), Attention Deficit Hyperactivity D/O, predominately inattentive presentation, and Parent-Child relational problem; -age 15 years old; -his 6/4/20 admission assessment indicated: previous residential and wilderness placement,	V 112		

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physical aggression, risky sexual behavior with adult men and subsequent pending legal charges, pending legal charge of domestic abuse, truancy and self-harm behaviors;
-Client #2 had treatment goals related to Trauma, Attachment Difficulties, Parent Child Relationship, Impulse Control and Compulsions, and Oppositional Defiant Behavior which were implemented in to his treatment plan on 6/24/20;
-Client #2's treatment plan failed to address what treatment strategies the facility would implement related to the client's sexualized behaviors, and Depression;

Review on 7/8/21 of Client #5's record revealed:
-date of admission: 10/26/20
-diagnoses: Generalized Anxiety D/O, Tobacco Use D/O, and Parent Child Relational Problem;
-age: 17 years old;
-his pre-admission referral indicated a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and academic issues;
-10/27/20 admission assessment indicated: history of substance use, anxiety, depression, self-harm behavior, suicidal ideation, family conflict, verbal and physical aggression, previous wilderness treatment and academic issues;
-Client #5 had goals in his treatment plan related to Anxiety, Parent Child Relationship, and Substance Abuse added to his Master Treatment Plan on 11/24/20;
-Client #5's treatment plan failed to address what strategies the facility would implement related to his Depression and Anxiety and did not carry over the diagnosis of ADHD;
-Client #5's goals related to his Anxiety were documented as "Client will" and did not indicate what the facility staff would develop and implement to help Client #5 achieve his goals or who would be responsible;

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V 112	Continued From page 14 Review on 6/24/21 of FC#6's record revealed: -date of admission: 6/25/20 -date of discharge: 9/25/20 -diagnoses: Adjustment Disorder, with (w/) mixed anxiety and depressed mood, Attention Deficit Hyperactivity Disorder (ADHD) Combined Presentation, Tourette's Disorder, Obsessive Compulsive Disorder (D/O), Specific learning disorder, w/impairment in written expression and Specific learning disorder w/impairment in reading; -17 years old; -his 6/25/20 admission assessment indicated: challenges with learning, defiance, physical aggression, wilderness treatment history, co-dependency issues, obsessive compulsive behaviors, and loss of a parent; -FC #6 had treatment goals related to Trauma, Learning Disability, Parent Child Relationship, Impulse Control and Compulsions, and ADHD which were implemented in to his treatment plan on 6/25/21; -all of FC #6's goals were changed to "resolved" on 7/16/20; even though he had not completed the program; -FC#6's interventions related to trauma and impulse control were documented as "Client will" and did not indicate what facility staff would be doing to help FC#6 achieve his goals or who would be responsible; -FC#6 was removed from the facility by his legal guardian on 9/25/20, against medical advice (AMA). Review on 7/7/21 of FC #7's record revealed: -date of Admission: 2/1/21 -date of Discharge: 3/24/21 -diagnoses: Major Depressive Disorder, Recurrent Episode, Severe; Generalized Anxiety	V 112		

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V 112	Continued From page 15 Disorder; Attention-Deficit Hyperactivity Disorder, Combined Presentation; Cocaine Use Disorder, Moderate; Unspecified Trauma and Stressor Disorder; Parent Child Relational Problem and Personal History of Self-Harm; -age: 15; -an admission assessment dated 2/2/21 indicated: -FC #7 "acknowledged his SI (suicidal ideation), self-harm urges, risky sexual conduct, and drug use as continued concerns for his parents ...[FC #7] was beginning to start sexting with peers and reach out to people in the internet to set up sexual encounters. [FC #7] was caught with porn on his phone and laptop ..." -his treatment plan failed to address his risky sexual conduct; -FC #7 had goals related to parent child relationship, depression/suicidal ideation, substance abuse, attention deficit hyperactivity disorder (ADHD), anxiety and trauma which were implemented onto his treatment plan on 2/23/21. -FC #7 was removed from the facility on 3/24/21 related to inappropriate sexual activity with an 18 year old client; FC #7's goals were changed to "resolved" on 3/24/21 even though he had not completed the program. Review on 7/7/21 of FC#8's record revealed: -date of admission: 01/14/20 -date of discharge: 03/25/21; -diagnoses: Major Depressive Disorder (D/O), Cannabis Use D/O, Unspecified Trauma and Stressor Related D/O, and Attention Deficit Hyperactivity D/O; -18 years old; -his 1/15/20 admission assessment indicated: a history of early childhood trauma, substance use, depression, suicidal ideation, self-harm	V 112		

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V 112	Continued From page 16 behaviors, misdemeanor indecent liberties between children as a minor, subsequent psychosexual therapy, probation, and psychiatric residential treatment facility placement; -FC#8's treatment plan failed to address his ongoing sexualized behavior at the facility and what strategies facility staff would implement to help FC#8 engage in appropriate behavior with peers. Further review on 7/7/21 of FC#8's therapy notes in the treatment plan revealed: -Client had 3 documented sessions regarding sexually acting out with a roommate and another peer prior to a treatment goal being added to his master treatment plan on 4/22/20, less than 6 months in to the program; -7/13/20 session notes noted, "working on poor choices, and bringing sexual temptation to his peers and not following healthy boundaries;" -7/30/20 session noted "working on past choices so far crossing boundaries and making unhealthy choices that are now following;" -8/10/20 session noted, "processing information that came from his peer around his sexually acting out again, client verified that he was sexually active with another student oral and anal ....resistant to accountability and recognition of his negative impact via his choices;" -9/10/20 session noted, "went over recent rumor that he had sexually acted out again with another student ...this was false and took accountability for saying some things that alluded to it as an unhealthy defense;" -10/12/20-Client had a closure session with his initial treating therapist; and there was only one more session noted regarding his behaviors of concern until discharge on 3/25/21; -Incident that occurred on 3/10/21 between FC#7 and FC#8 that prompted an internal investigation	V 112		

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V 112	Continued From page 17 on 3/18/21 by the facility was not included in any therapy notes or treatment plan; -FC#8's treatment plan failed to address the client's ongoing sexualized behavior while at the facility and failed to address what strategies the facility implemented to help FC#8 engage in healthy interactions with peers; -FC#8 was administratively discharged on 3/25/21; Review on 6/30/21 of notes from the facility's internal investigation completed on 3/18/21 regarding an incident of inappropriate sexual behavior between students FC#8 and FC#7 on 3/10/21 revealed: -interview documentation with students that were on campus on 3/18/21 that were asked open ended questions; -other incidents of sexualized behaviors between students and bullying on campus were revealed during interviews; -local law enforcement was notified of this incident; -there was no information in this documentation as to what conclusions the facility came to on 3/18/21 or any changes made to ensure clients were being kept safe; -this was not the first documented incident of sexual behavior between FC#8 and other students; -further review of interview documentation revealed: -Client#1 reported that, "[Client #5] didn't feel comfortable switching rooms because [FC#8] was touching him inappropriately;" -FC #8's former roommate reported: "I'm concerned about a certain student [FC#8] manipulating kids... who gets students to explore their sexuality, then when they try something once, they use it against them ...[FC#8] played	V 112		

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with another peers hair and when he told him don't touch me ....[FC#8] said I'll tell everyone you let me suck your d**k if you tell to stop again."
-FC#8's former roommate also reported, "I'm uncomfortable with how racist and homophobic people act around here ...even when they think it's funny, it's not ok ...examples were given;"
-FC#7 reported, [FC#8] in winter sucked my d**k ....this was a couple weeks ago ....[FC#8] would do something stupid and sexual and I'd say ...f**k you ...We were in gym class, we were sitting together ...I don't remember what led up to it and he said "Pull out your d**k ...I wasn't thinking ...and so I did."
-FC#7 reported that "he and [FC#8] were in the little room in the gym to the right;"
-FC#8 reported, "he has not engaged in any sexual interactions as of recent with any other student on campus;"
-FC#8 denied the 3/10/21 incident;
-FC#8 reported he gave another student a b*****b upon that student's request in January ...(this interview was conducted 3/18/21)...and that student had left the program in early February per documentation;"
-Client#2 reported that in December another student (unaudited former client) entered the rooms of FC#8 and another unaudited former client and tried to put his hands down each of their pants ...this unaudited clients' advances were allegedly unwelcome;"
-a separate unaudited former client reported, "[Client#2] bragged about having sex with another unaudited former client and several others (no names) ....that another former unaudited client bragged about having sex with many people across a lot of the dorms ...all consensual ...that [FC#8] bragged about having sex with 9 people (can't remember exact names, [names 3 students] past students that he doesn't know)

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V 112	Continued From page 19 ...FC#8 bragged about touching other people inappropriately ...another unaudited client told another audited client that [FC#8] grabbed his penis and that if he told anybody he would tell everyone he is gay ...[Client #5] has said that [FC#8] has kissed him on his head, touched him etc., [FC#8] has been inappropriate with me, trying to get me to talk about sex with other people, and then commenting that he would like to do that with me ...made me uncomfortable ..." there was a comment in the documentation prior to this disclosure by the Executive Director stating that "none of the below have been confirmed, likely rumors and only student who reported these issues, quite concerning nonetheless);" -Client #5 reported that he "is a friend of [FC#8] but wants to learn to set better boundaries with him because [FC#8] is a little too touchy ...FC#8 has touched and kissed his hand which he feels uncomfortable about" ...he wants help learning how to set clear boundaries;" -FC#10 reported, [Client #5] complaining about [FC#8] ...that he kissed his hand and stroked his leg ...he further reported he [FC#10] slept in the common area because a peer [FC#8] made him uncomfortable, because he sprayed a spray on his face ...and one night his bed was shaking, no-one else reported in [FC#8']s bed during this time but reported ....he was probably doing something inappropriate" -another unaudited client reported, that kids in the dorm say they are uncomfortable with [FC#8]; -a separate unaudited client reported, that "racism, anti-Semitic jokes, comments, homosexual noises/homophobic comments throughout the day, and bullying made him uncomfortable;" Review on 7/1/21 of email dated 7/1/21 at 5:06pm, sent to Divison of Health Service	V 112		

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V 112	Continued From page 20 Regulation (DHSR from the Executive Director (ED) regarding FC#8's discharge revealed: -"When there was alleged consensual sexual activity between [FC#8] and another student in the weeks leading up to his discharge, [FC#8] denied having engaged with that peer and sexual activity could not be substantiated;" -FC#8 was within 4 weeks of graduation ... Acknowledging the growth that [FC#8] had experienced and his upcoming transition, it was the recommendation of program staff that [FC#8] discharge earlier than initially planned." Review on 7/8/21 of Former Client #10's record revealed: -date of admission: 03/23/20 -date of discharge: 06/14/21 -diagnoses: Major Depressive Disorder, recurrent, moderate, and Generalized Anxiety Disorder; -age: 16 -his 3/24/20 admission assessment indicated a history of anxiety, manipulation of family system, truancy, wilderness treatment, and previous Arson charge; -FC#10's treatment plan failed to address what strategies the facility would implement to help him manage and improve his Anxiety and Depression; -FC #10's treatment plan also failed to address his concerns with being harassed by FC#8 and sleeping in the common area for a period of weeks. Interview on 6/24/21 with Client #2 revealed: When asked about his treatment plan, Client #2 reported that they "made a treatment plan when I got here ....made anger management goals ... most of my goals are related to individualized phase work."	V 112		

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V 112	Continued From page 21 Interview on 6/29/21 with FC#6's guardian revealed: -she had significant concerns with the facility's treatment; -They "convinced me that my son had to stay for a year;" -they said "I was damaging my son by bringing him home before he was ready ... It was the opposite of therapeutic;" -"kids were torturing animals (referencing "nuggeting" where limbs are ripped off of lizards, frogs, or bugs) and this came up in therapy and I brought him home within 48 hours." -"they make you sign a contract at admission that anything you say can be held against you;" Attempts to interview FC#8 and his legal guardians were unsuccessful during the survey. Attempts to interview FC#8's prior therapists were unsuccessful during the survey. Interview on 7/6/21 with FC#10 revealed: -"I was sexually harassed while I was there;" -"I had a roommate ask me to do sexual favors ...he was going to tell everyone I did stuff ...I told staff and he got put on Safety and later they tried to put me back in a room with him and I refused ....I told staff, I told the residential director, I told every single one." Interview on 7/6/21 with FC#10's legal guardian revealed: -she thought she might get a call from DHSR surveyors; -she reported being actively involved in FC#10's treatment; -she confirmed that she had to sign a non-disparagement agreement regarding the facility and was concerned about saying	V 112		

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V 112	Continued From page 22 disparaging remarks about the facility; Review on 7/7/21 of the facility's non-disparagement agreement revealed: -a document that the facility has legal guardians sign during admission of clients agreeing that legal guardians nor their family members, friends, or associates will not say anything negative about the facility or risk legal action; -the document states, "legal guardian/parent agree that they will not publicly criticize, ridicule, defame, or disparage Equinox or its conduct, services, practices, policies, facilities, personnel, management, directors, officers, or otherwise communicate about Equinox, its conduct, services, practices, policies, facilities, personnel, management, affiliates, directors, or officers in a disparaging or negative manner in any medium (including online or through social media) to any person or entity without limitation in time ...Parents/Custodian further agree to not encourage family members, friends, agents or other third parties from, and shall take any and all reasonable steps to prevent or persuade others with whom they have familial or social relationships from, any public criticism, ridicule, defamation, or disparagement of Equinox, its conduct, its practices, services policies, facilities, personnel, management, affiliates, directors, or officers. The Parties to this agreement agree and acknowledge that this non-disparagement provision is a material term of this Agreement, the absence of which would have resulted in Equinox declining to enter into this agreement ....Parent/Guardian further agree and acknowledge that damages arising from breach of this provision may be difficult to identify and that the potential harms arising from such a breach are likely to be of an ongoing nature, cannot reasonably or adequately be	V 112		

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compensated by damages in any action at law, and constitute irreparable injury or damage ... Therefore, Parents/Custodians expressly agree and acknowledge that Equinox shall be entitled to seek and obtain injunctive relief in the event of, or to prevent, any breach of this non-disparagement provision by Parents/Custodians or third parties ...In the event of a violation of this non-disparagement provision by Parents/Custodians or third parties, Equinox shall also have the right to monetary relief, and recovery of reasonable attorney fees and costs incurred in seeking either monetary or injunctive relief, regardless of the number or instances of alleged breaches of this agreement."

Interview on 7/9/21 with therapist #1 revealed:
-she confirmed that therapists develop the treatment plans with clients;
-when asked where strategies related to sexualized behaviors of clients would be found in the treatment plan, specifically as it relates client #2, she reported , "its not as explicitly mentioned as DHSR would like to see;"
-she reported that she tried to rectify this with Client#2's newest treatment plan within last few weeks;
-she reported that strategies around his goals were linked in other ways in his treatment plan;
-she reported that Client #2's behaviors "were not a risk to other peers as long as its consensual and a coping mechanism ... It is not of a danger;"
-she reported speaking to administrative staff regarding Client#2 and direct care staff as well;

Interview on 7/9/21 with therapist #2 revealed:
-she confirmed therapists develop the treatment plans with clients;
-when asked where the documentation of facility strategies for client goals were, she indicated that

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they were in the treatment team meetings held weekly;"
-when asked where the documentation of strategies regarding clients sexualized behaviors were in treatment plans, her response was that "this is an area of growth for their department ...and they were putting more information in notes now;"
-she did feel like FC#8 was a risk to the other kids and had conversations with her supervisor, FS#30, other therapist, and administration regarding this;
-she reported that "the facility tries to make sure kids get their clinical needs met and discussing meeting the needs of the kid that is sexually acting out versus meeting the needs the rest of the milieu, the facility had to have a former client leave."

Interview on 7/13/21 with Former Staff #30 revealed:
-his last day at the facility was 7/2/21 and had been there since 7/2019;
-he supervised the clinical team, including therapists who created and developed the treatment plans;
-he reported that the "facility specific strategies would be in the treatment plans under interventions;"
-he reported that if a client acted out, they would update treatment plan;
-regarding FC#8 and documentation in therapy notes about FC#8 acting out sexually; he reported he couldn't speak to that therapist's notes;

Interview on 7/9/21 with the Executive Director (ED) revealed:
-"The primary therapist is directly responsible for confirming the treatment plans address the needs of clients and for updating the plans;"

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V 112	Continued From page 25 - When asked what the final conclusion was related to the internal investigation in March of 2021 which revealed sexual behaviors between clients, ED reported that: "We shared with you the document that further explained some of those pieces ... there were a few of the items noted in the document that we were aware of and it had been addressed...We investigated it and it was fully dealt with;" "Ultimately the conclusion was that we completed a retraining with staff members on supervision" and [FC#8] was put in direct eyesight for a brief period of time ...until he left the program;" -When asked about prior sexualized behaviors with [FC#8], ED reported: "I had heard of previous mild engagements that had been addressed within therapy .. kissing is a mild sexual encounter which would be addressed by the therapist;" -When asked if oral sex and anal sex would be major, the ED reported, "If disclosed in therapy we would follow our sexual allegations protocol;" -When asked if [FC#8] was involved in anything major, ED reported: "I heard rumors in which he was involved in major activities, but it would have been investigated by the therapist ... In the interviews we did, [FC#8] said he engaged in orall sex with a prior student, but I had no way to substantiate it and it's not a situation I know of happening, but I know it is a situation I am aware of that he reported;" -When advised that upon review of client records, there was no documentation in the therapy sessions or crisis interventions notes about the inappropriate client behaviors, investigation of said behaviors, and interventions put in place as a result of these behaviors, ED reported that he was "not sure how to answer ....at this point were put in there would be an incident report related to an allegation, there would be some notation in the	V 112		

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V 112	Continued From page 26 crisis intervention note that an investigation had been done and what the outcomes were and then the ensuing response to it;" -he further reported, "prior to the utilization of critical incident reports I would have expected for that kind of notation to be found in the client file likely in individual therapy notes ... Rough estimate that we started crisis intervention notes at the beginning of March or end of February 2021... We have trained our therapists to do this at this point." -There was no documentation available for review that detailed an internal investigation or any measures taken to protect clients from bullying and sexual predation. This deficiency constitutes a recited deficiency and is cross referenced in to 10A NCAC 27 G .1301 Scope (V179) for Type A1 rule violation and must be corrected within 23 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.	V 114		

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V 114	Continued From page 27	V 114		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to conduct fire and disaster drills on each shift at least quarterly. The findings are:

Review on 6/24/21 of the facility's fire and disaster drill log revealed:
- No documentation of fire drills during the following shifts and quarters:
- July - September 2020: 1st, & 2nd shifts;
- October - December 2020: 1st, shift;
- January - March 2021: 2nd & 3rd shifts;
- April - June 2021: 2nd & 3rd shifts

- No documentation of disaster drills during the following shifts and quarters:
- July - September 2020: 1st, 2nd & 3rd shifts;
- October - December 2020: 2nd & 3rd shifts;
- January - March 2021: 2nd & 3rd shifts;
- April - June 2021: 2nd & 3rd shifts

Interview on 6/24/21 and 7/9/21 with the Executive Director revealed:
-"there are holes in the schedule;"
-"this has been a challenge that we have addressed several times;"
-the responsibility for ensuring that fire/disaster drills were completed involved both the former residential program director and maintenance technician ...both of which I supervise;
-he reported that facility had a quality assurance meeting on Tuesday, 6/22/21 and were implementing a new PDSA (Plan Do Study Act) to ensure that fire and disaster drills were done timely moving forward.

This deficiency is cross referenced in to 10A

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V 114	Continued From page 28 NCAC 27 G .1301 Scope (V179) for Type A1 rule violation and must be corrected within 23 days.	V 114		
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; (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.	V 118		

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V 118	Continued From page 29	V 118		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure medications were only administered by staff trained by a registered nurse (RN), pharmacist, or other legally qualified person affecting 4 of 5 audited current clients (Client #1, #2, #3 and #4). The findings are:

Review on 7/1/21 of the facility's Medication Administration Check Off and Certification form revealed:
-Staff were required to be certified in cardiopulmonary resuscitation (CPR) and first aid in order to be trained in medication administration.
-This facility policy limited the number of staff who were eligible to be trained in medication administration.

Review on 6/28/21 of Staff #11's record revealed:
-A hire date of 4/13/20.
-There was documentation that he completed the online portion of CPR/First Aid training on 3/1/21.
-There was no evidence a hands-on skills session had been completed with a CPR instructor.
-There was no documentation of medication administration training.

Review on 7/1/21 of the MAR Edit History for Staff #11 revealed:
-The RN created an electronic account for Staff #11 to access client MAR's on 2-23-21.

Review on 6/25/21 of Client #1's record revealed:
-Date of Admission: 10/30/20.
-Age: 18.

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V 118	Continued From page 30 -Diagnoses: Generalized Anxiety Disorder; Cannabis Dependence, Uncomplicated; Dysthymic Disorder. -Physician's orders for the following medications: -Clonazepam 0.5 milligram (mg) 1 tablet by mouth every evening (treats anxiety). -Fluvoxamine Maleate 100 mg 1 tablet by mouth every morning (treats anxiety). -Methylphenidate extended release (ER) 27 mg 1 tablet by mouth every morning (treats attention-deficit/hyperactivity disorders). -Multivitamin 1 tablet by mouth every morning (supplement). -Vitamin D3 2,000 International Units (IU) 1 tablet by mouth every day (supplement). -Melatonin 10 mg 1 gummy by mouth at bedtime as needed for sleep. -Melatonin 5 mg chew 2 gummies by mouth at bedtime as needed for sleep. -Trazodone 150 mg 1 tablet by mouth at bedtime as needed for sleep. Review on 6/24/21 of Client #1's Medication Administration Records (MAR's) for April 2021 through June 2021 revealed: -Staff #11 administered 50 doses of prescribed medications to Client #1. Review on 6/25/21 of Client #2's record revealed: -Date of Admission: 6/4/20. -Age: 15. -Diagnoses: Major Depressive Disorder, Recurrent, Moderate; Adjustment Disorder; Generalized Anxiety Disorder; Oppositional Defiant Disorder (ODD); Attention-Deficit Hyperactivity Disorder (ADHD), Predominately Inattentive Presentation and Parent-Child Relational Problem. -Physician's orders for the following medications: -Aripiprazole 2 mg 2 tablets by mouth every	V 118		

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evening (treats mood disorders).
-Dapsone 7.5% gel pump apply topically to affected areas at bedtime (treats acne).
-Emtricitabine/tenofovir 200/300 mg 1 tablet by mouth daily (treats/prevents human immunodeficiency virus).
-Fluoxetine hydrochloride (HCL) 20 mg 1 capsule by mouth every morning (treats depression).
-Guanfacine HCL ER 2mg 1 tablet by mouth daily (treats ADHD).
-Nordic Naturals Ultimate Omega 2 capsules by mouth daily (supplement).
-Vyvanse 40 mg 1 capsule by mouth daily in the morning (treats ADHD).
-Menthol Cough Drops 5 mg Lozenge dissolve 1 drop slowly in mouth every 2 hours as needed for cough/sore throat.
- Compound W (salicylic acid) 40% pads wash affected area, soak area in warm water for 5 minutes, dry area thoroughly, apply medicated pad as needed for warts.

Review on 6/24/21 of Client #2's MAR's for April 2021 through June 2021 revealed:
-Staff #11 administered 72 doses of prescribed medications to Client #2.

Review on 6/25/21 of Client #3's record revealed:
-Date of Admission: 4/6/21.
-Age: 14.
-Diagnoses: Generalized Anxiety Disorder; Panic Disorder; Major Depressive Disorder.
-Physician's orders for the following medications:
-Aripiprazole 2 mg 1 tablet by mouth daily in the morning (treats mood disorders).
-Aripiprazole 5 mg 1 tablet by mouth at bedtime (treats mood disorders).
-Bupropion HCL 100 mg 1 tablet by mouth daily in the morning (treats depression).

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-Buspirone HCL 7.5 mg 1 tablet by mouth daily (treats anxiety).
-Melatonin 5 mg 1 tablet by mouth at bedtime as needed for sleep.

Review on 6/24/21 of Client #3's MAR's for April 2021 through June 2021 revealed:
-Staff #11 administered 48 doses of prescribed medications to Client #3.

Review on 6/25/21 of Client #4's record revealed:
-Date of Admission: 3/15/21.
-Age: 14.
-Diagnoses: Major Depressive Disorder, Recurrent Episode, Moderate; Cannabis Use Unspecified, Uncomplicated; Unspecified Trauma and Stressor Related Disorder; Attention Deficit Hyperactivity Disorder, Predominantly Hyperactive/Impulsive Presentation.
-Physician's orders for the following medications:
-Dexmethylphenidate ER 5 mg 1 capsule by mouth daily (treats ADHD).
-Fluoxetine HCL 10 mg 1 capsule by mouth daily with 20 mg capsule to equal 30 mg total (treats depression).
-Fluoxetine HCL 20 mg 1 capsule by mouth daily with 10 mg capsule to equal 30 mg total (treats depression).
-Trazodone 50 mg 1/2 tablet (25 mg) by mouth at bedtime (treats insomnia).
-Gas relief 80 mg 1-2 tablets by mouth after meals and at bedtime as needed for bloating, pressure, symptoms referred to as gas.

Review on 6/24/21 of Client #4's MAR's for April 2021 through June 2021 revealed:
-Staff #11 administered 31 doses of prescribed medications to Client #4.

Review on 6/28/21 of RN records of facility staff

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trained in medication administration revealed:
-Medication administration training certificates were kept inside a 3-ring binder in the RN's office.
-There was documentation to indicate that the following staff were trained to administer medications:
-Staff #1 attended class 2/25/20 and completed training on 3/11/21.
-Staff #5 attended class on 9/19/19 and completed training on 10/9/19.
-Staff #12 attended class 12/12/19 and completed training 3/8/20.
-Staff #13 attended class on 1/13/21 and completed training on 3/1/21.
-Staff #15 attended class 1/12/21 and completed training on 3/24/21.
-Staff #18 attended class on 12-10-20 and completed training on 2/4/21.
-Staff #21 attended class 1/12/21 and completed training 2/8/21.
-Staff #23 attended class 8/13/20 and completed training on 9/4/20.
-Staff #30 attended class 9/17/20 and completed training on 10/5/20.
-There was no documentation to indicate Staff #11 had been trained in medication administration.

Review on 6/28/21 of the facility's ONM (overnight mentor) Shift Report notes dated 4/24/21-6/28/21 revealed:
-On 6/12/21 a shift note at 11:00 pm indicated "student requested ibuprofen for a small cut on the inside of his lip. Medical on call was contacted soon after but no response as of midnight. Student was frontloaded with the expectation that it might be denied just on the grounds that none of the ONM (overnight mentor) staff are med trained."
-On 6/24/21 a shift note at 2:00 am indicated a

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student "ask staff for congestion medication. Staff let student know none of the ONM was med train. Staff suggested for student to take a warm shower to see if that might help ..."

Review on 6/29/21 of the overnight schedule for facility staff from 4/14/21 through 7/3/21 revealed:
-There were a total of 17 staff members on the schedule.
-Only one of the staff members (Staff #15) was trained in medication administration.
-There were 56 shifts out of 77 shifts in which there was not a trained staff member to administer medications as follows: 4/18/21; 4/21/21 through 4/25/21; 4/28/21 through 4/29/21; 5/1/21 through 5/2/21; 5/5/21 through 5/16/21; 5/19/21 through 5/23/21; 5/26/21 through 5/30/21; 6/2/21 through 6/6/21; 6/9/21 through 6/13/21; 6/16/21 through 6/20/21; 6/23/21 through 6/27/21 and 6/30/21 through 7/3/21.

Interview on 6/28/21 with the RN revealed:
-She conducted medication administration training for facility staff.
-Staff usually signed a roster when they attended training.
-She did not have a roster with Staff #11's signature.
-She usually sent an email to management when a staff member became eligible to administer medications.
-She did not have an email to indicate Staff #11 was eligible to administer medications.
-She did not forward documentation of medication training to the Human Resource (HR) Manager.
-She did not know why medication administration training records were kept in the RN's office instead of staff personnel files.
-There were no electronic copies of the

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V 118	Continued From page 35 medication administration training records. -Whenever a staff member resigned, she threw away their record of medication administration training. Interview on 7/9/21 with the Executive Director revealed: -The RN should have sent medication administration training records to the HR Manager. -The HR Manager was responsible for ensuring the training was completed and filed correctly. -He stated, "I am aware the RN threw away certifications and there was immediate training after that involving our entire team and not just the nurse." -He directly supervised the RN and the HR Manager. This deficiency is cross referenced into 10A NCAC 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 118		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.	V 131		

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V 131	Continued From page 36 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to access the Health Care Personnel Registry (HCPR) prior to hiring 7 of 36 of audited current staff (staff #4,staff #7, staff #14, staff #17, staff #25, staff #28, and staff #29) and 1 of 4 audited former staff (FS #33). The findings are: Review on 6/30/21 and 7/14/21 of facility personnel records revealed: -staff #4 date of hire was 3/13/19 and HCPR check was completed on 3/22/19; -staff #7 date of hire was 1/28/19 and HCPR check was completed on 3/11/2019; -staff #14 date of hire was 3/2/20 and HCPR check was completed on 10/26/20; -staff #17 date of hire was 5/26/21 and HCPR check was completed on 6/10/21; -staff #25 date of hire was 3/1/18 and HCPR check was completed on 7/24/20; -staff #28 date of hire was 4/12/18 and HCPR check was completed on 4/19/18; -staff #29 date of hire was 3/16/20 and HCPR check was completed on 7/14/20; -former staff #33 date of hire was 3/13/19 and HCPR check was completed on 3/18/19. Interview on 6/30/21 and 7/9/21 with Executive Director (ED) revealed: -he was unaware that this had occurred; -the facility's external audit had gone virtual during COVID and had missed these items; -the facility had a new Human Resources manager coming on and would address these issues so it wouldn't happen again. This deficiency is cross referenced in to 10A NCAC 27 G .1301 Scope (V179) for Type A1 rule violation and must be corrected within 23 days.	V 131		

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V 179	27G .1301 Residential Tx - Scope 10A NCAC 27G .1301 SCOPE (a) The rules of this Section apply only to a residential treatment facility that provides residential treatment, level II, program type service. (b) A residential treatment facility providing residential treatment, level III service, shall be licensed as set forth in 10A NCAC 27G .1700. (c) A residential treatment facility for children and adolescents is a free-standing residential facility which provides a structured living environment within a system of care approach for children or adolescents who have a primary diagnosis of mental illness or emotional disturbance and who may also have other disabilities. (d) Services shall be designed to address the functioning level of the child or adolescent and include training in self-control, communication skills, social skills, and recreational skills. Children or adolescents may receive services in a day treatment facility, have a job placement, or attend school. (e) Services shall be designed to support the child or adolescent in gaining the skills necessary to return to the natural, or therapeutic home setting. (f) The residential treatment facility shall coordinate with other individuals and agencies within the client's system of care. This Rule is not met as evidenced by:	V 179		

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V 179	Continued From page 38 Based on record reviews and interviews, the facility failed to operate within the scope of their program which is to provide a structured living environment within a system of care approach for adolescents who have diagnoses of mental illness, emotional disturbance or other disabilities, affecting 5 of 5 audited current clients (Client #1, #2, #3, #4 and #5) and 5 of 5 audited former clients (FC #6, FC #7, FC #8, FC #9 and FC #10) and 11 non-audited former clients. The findings are: CROSS REFERENCE: 10A NCAC 27G.0202 Personnel Requirements (V108). Based on record reviews and interview, the facility failed to ensure staff were trained to meet the needs of the clients for 33 of 36 audited current staff (the registered nurse (RN) and Staff #1-32). The facility also failed to ensure at least one staff member trained in basic first aid and cardiopulmonary resuscitation (CPR) was available at all times while clients were present. CROSS REFERENCE: 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record reviews and interviews, 4 of 4 audited professionals (Therapist #1, Therapist #2, the Registered Nurse (RN) and the Executive Director (ED)) failed to demonstrate knowledge, skills and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G.0205 Assessment and Treatment/Habilitation of Service Plan (V112). Based on record review and interview, the facility failed to develop and implement treatment strategies for 2 of 5 audited current clients (Clients #2 and #5) and 4 of 5 audited former clients (FC #6, FC #7, FC #8, and	V 179		

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V 179	Continued From page 39 FC #10). CROSS REFERENCE: 10A NCAC 27G.0207 Emergency Plans and Supplies (V114). Based on record reviews and interviews, the facility failed to conduct fire and disaster drills on each shift at least quarterly. CROSS REFERENCE: 10A NCAC 27G.0209 Medication Requirements (V118). Based on record reviews and interviews, the facility failed to ensure medications were only administered by staff trained by a registered nurse (RN), pharmacist, or other legally qualified person affecting 4 of 5 audited current clients (Client #1, #2, #3 and #4). CROSS REFERENCE: General Statute 131E-256 Health Care Personnel Registry (V131). Based on record review and interview, the facility failed to access the Health Care Personnel Registry (HCPR) prior to hiring 7 of 36 of audited current staff (staff #4,staff #7, staff #14, staff #17,staff #25, staff #28, and staff #29) and 1 of 4 audited former staff (FS #33). CROSS REFERENCE: 10A NCAC 27E.0107 Training on Alternatives to Restrictive Interventions (V536). Based on record reviews and interview, the facility failed to ensure 21 of 36 audited current staff (Staff #1, #3, #6, #7, #8, #12, #13, #14, #15, #16, #17, #18, #21, #22, #24, #25, #26, #27, #28, #31 and #32) had training in alternatives to restrictive interventions prior to providing services. CROSS REFERENCE: 10A NCAC 27E.0108 Training in Seclusion, Physical Restraint and Isolation Time-Out (V537). Based on record reviews and interview, the facility failed to ensure	V 179		

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V 179	Continued From page 40 21 of 36 audited current staff (Staff #1, #3, #6, #7, #8, #12, #13, #14, #15, #16, #17, #18, #21, #22, #24, #25, #26, #27, #28, #31 and #32) had training in the use of seclusion, physical restraints and isolation time out prior to providing services. CROSS REFERENCE: 10A NCAC 27G.0302 Facility Construction/Alterations/Additions (V722). Based on observation, interview and record review, the facility failed to consult with the Division of Health Service Regulation Construction Section prior to additions made to the facility (Spring Dorm). CROSS REFERENCE: 10A NCAC 27G.0303 Location and Exterior Requirements (V736). Based on observation and interview, the facility failed to maintain the facility and grounds in a safe, clean, attractive, and orderly manner. CROSS REFERENCE: 10A NCAC 27G.0304 Facility Design and Equipment (V778). Based on interview and record review, the facility failed to ensure that children and adolescents did not share a bedroom with an adult affecting 4 of 5 audited current clients (Clients #1, #2, #4, #5) and 3 of 5 audited former clients (FC #7, FC #8, FC #10) and 11 non-audited former clients. Review on 7/14/21 of the Plan of Protection (POP) dated and signed by the Owner (Business Development Director/Admissions Director) on 7/14/21 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 1. 10A NCAC 27G.0202 Personnel Requirements - (H) (V108) CPR/First Aid requirements (Items a-d Previously Submitted 6/30/2021): a. A minimum of one staff member who is trained in CPR will be onsite for each shift, 24 hours a	V 179		

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V 179	Continued From page 41	V 179		

day, effective immediately.
b. A CPR trained staff member has been identified to work the overnight shift the night of Wednesday, June 30, 2021.
c. An in-service run by a registered nurse is scheduled for Thursday, July 1, 2021 for CPR training to confirm that a sufficient number of daytime and overnight staff are trained to meet the above.
d. A CPR-trained staff will be on-call for coverage purposes in case of emergencies until there are a minimum of two CPR-trained staff members scheduled for every shift.
e. New Clinical Director and Program Director (starting 7/19) will come up with a process by 7/21 to train staff on client-specific and diagnosis-specific treatment strategies. Training will be ongoing.
2. 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109):
a. Identified staff will receive counseling from HR (Human Resource) Department or Governing body on noted discrepancies. They will be provided with ongoing training in identified areas by 7/23/21.
b. The Governing Body (including Owner; Academic Director; Clinical Director; Program Director; HR/Operations Manager) will assess identified staff for job performance and needs for training on a monthly basis. The next Governing Body Meeting will take place on 7/22/21.
3. 10A NCAC 27G.0205 Assessment and Treatment/Habilitation or Service Plan (V112):
a. Therapists will be inserviced by 7/19/21 on Treatment Plans and their inclusion of strategies, specifically including language focused on what the facility and staff will do to complete the strategy, and
b. New Clinical Director will create a plan by

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V 179	Continued From page 42 7/23/21 on consistent documentation of interventions that include the restriction of client rights (e.g., Safety Phase, Communication Block, Use of Calm Room, etc.)-including the location of that documentation. Such documentation will include, but not limited to the following: i. Expected duration; ii. Restrictions associated with intervention; iii. Requirements for completion of intervention; iv. Approval of intervention 4. 10A NCAC 27G.0207 Emergency Plans and Supplies (V114): a. Fire drills will be conducted weekly starting 7/15/21 until all staff have been trained. b. Once complete, fire drills will be completed monthly. c. Disaster drills will be conducted monthly until substantial compliance is maintained per determination of the Governing Body. 5. 10A NCAC 27G.0209 Medication Requirements (V118) (Plan Previously Submitted 6/30/2021): a. A minimum of one staff member who is trained in medication administration will be onsite for each shift, 24 hours a day, effective immediately. b. A medication administration trained staff member has been identified to work the overnight shift the night of Wednesday, June 30, 2021. c. An in-service run by a registered nurse is scheduled for Thursday, July 1, 2021 for medication administration to confirm that a sufficient number of daytime and overnight staff are trained to meet the above. d. A medication-trained staff will be on-call for coverage purposes in case of emergencies until there are a minimum of two medication-trained staff members scheduled for every shift. 6. General Statute 131E-256 Health Care Personnel Registry (V131):	V 179		

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a. Leadership team will be inserviced on 7/15/21 that no employee can start or fill-out new-hire paperwork until they have been cleared through the healthcare registry.
b. HR/Operations manager is the double-check system, and will not fill out new hire paperwork or let an employee start without checking the healthcare registry. Inservice on this information will be completed on 7/15/21.
7. 10A NCAC 27E.0107 Training on Alternatives to Restrictive Interventions (V536):
a. Audit will be completed including all staff who are fully trained in CPI (Crisis Prevention Intervention). Staff who are not current in CPI training will not be allowed to provide direct supervision for students until re-certified. Audit will be completed by 7/16/21.
b. Once all staff are trained, an audit of CPI trained staff will be added to CQAC (Compliance and Quality Assurance Committee) meetings monthly.
8. 10A NCAC 27E.0108 Training in Seclusion, Physical Restraint and Isolation Time-Out (V537):
a. HR/Operations manager, Program Director, Clinical Director, Executive Director and CPI Trainer will be inserviced on 7/23/21 on the documentation that is required for Seclusion, Physical Restraint and Isolation Time-Out training, including:
i. Who participated in the training and the outcomes (pass/fail);
ii. When and where they attended;
iii. Instructor's name; and
iv. Service providers shall maintain documentation of initial and refresher training for at least three years.
9. 10A NCAC 27G.0302 Facility Construction/Alterations/Additions (V722):
a. Calm room was closed on 7/9/21 and will not be used until state construction section approval

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V 179	Continued From page 44 has been obtained. 10. 10A NCAC 27G.0303 Location and Exterior Requirements (V736): a. Water temps will be tested weekly starting 7/19. If any temperature is out of range of 100 - 116 degrees, maintenance will address immediately. b. Weekly physical plant rounds will begin the week of 7/19 and will assess for cleanliness and any physical plant issues that are in disrepair. Upon identification, a plan will be put in place to repair. 11. 10A NCAC 27G.0304 Facility Design and Equipment (V778): a. The Equinox RTC Policy and Procedure manual has been updated to clarify that children and adolescents shall not share a bedroom with an adult. b. Residential and Clinical staff will be inserviced beginning 7/14/21 to include that 18 year olds must be in a room of their own and are only able to share a bedroom with other 18 year old residents. 12. All above Tags are crossed into 10A NCAC 27G.1301 Scope (V179) for Type A1 Administrative Action: a. New HR/Operations Manager started 6/30/21. Training will include proper maintenance of employee files. b. New Clinical Director and Program Director start 7/19/21. They will review Equinox Policies and Procedures against state regulations pertaining to .1300 Residential Treatment and make suggestions for updates, as needed, by 7/28/21. Describe your plans to make sure the above happens. 1. A CQAC meeting will be held for each area not in compliance. The CQAC committee will decide whether audits are completed daily, weekly,	V 179		

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monthly, etc. The next CQAC meeting will be held on 7/20/21. Then, recommendation will be sent to the Governing Body for approval on 7/22/21.
2. The above plans will be implemented until sufficient compliance is met and maintained as determined by the Governing Body."

Review on 7/14/21 of the Addendum to the POP dated and signed by the Owner (Business Development Director/Admissions Director) on 7/14/21 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
1. 10A NCAC 27G.0202 Personnel Requirements - (H) (V108) CPR/First Aid requirements (Items a-d Previously Submitted 6/30/2021):
a. A minimum of one staff member who is trained in CPR will be onsite for each shift, 24 hours a day, effective immediately.
b. A CPR trained staff member has been identified to work the overnight shift the night of Wednesday, June 30, 2021.
c. An in-service run by a registered nurse is scheduled for Thursday, July 1, 2021 for CPR training to confirm that a sufficient number of daytime and overnight staff are trained to meet the above.
d. A CPR-trained staff will be on-call for coverage purposes in case of emergencies until there are a minimum of two CPR-trained staff members scheduled for every shift.
e. New Clinical Director and Program Director (starting 7/19) will come up with a process by 7/21 to train staff on client-specific and diagnosis-specific treatment strategies. Training will be ongoing.
2. 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109):
a. Identified staff will receive counseling from HR

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V 179	Continued From page 46 (Human Resource) Department or Governing body on noted discrepancies. They will be provided with ongoing training in identified areas by 7/23/21. b. The Governing Body (including Owner; Academic Director; Clinical Director; Program Director; HR/Operations Manager) will assess identified staff for job performance and needs for training on a monthly basis. The next Governing Body Meeting will take place on 7/22/21. 3. 10A NCAC 27G.0205 Assessment and Treatment/Habilitation or Service Plan (V112): a. Therapists will be inserviced by 7/19/21 by new Clinical Director on Treatment Plans and their inclusion of strategies, specifically including language focused on what the facility and staff will do to complete the strategy, and b. New Clinical Director will create a plan by 7/23/21 on consistent documentation of interventions that include the restriction of client rights (e.g., Safety Phase, Communication Block, Use of Calm Room, etc.)-including the location of that documentation. Such documentation will include, but not limited to the following: i. Expected duration; ii. Restrictions associated with intervention; iii. Requirements for completion of intervention; iv. Approval of intervention 4. 10A NCAC 27G.0207 Emergency Plans and Supplies (V114): a. Fire drills will be conducted weekly starting 7/15/21 until all staff have been trained. b. Once complete, fire drills will be completed monthly. c. Disaster drills will be conducted monthly until substantial compliance is maintained per determination of the Governing Body. 5. 10A NCAC 27G.0209 Medication Requirements (V118) (Plan Previously Submitted	V 179		

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V 179	Continued From page 47 6/30/2021): a. A minimum of one staff member who is trained in medication administration will be onsite for each shift, 24 hours a day, effective immediately. b. A medication administration trained staff member has been identified to work the overnight shift the night of Wednesday, June 30, 2021. c. An in-service run by a registered nurse is scheduled for Thursday, July 1, 2021 for medication administration to confirm that a sufficient number of daytime and overnight staff are trained to meet the above. d. A medication-trained staff will be on-call for coverage purposes in case of emergencies until there are a minimum of two medication-trained staff members scheduled for every shift. 6. General Statute 131E-256 Health Care Personnel Registry (V131): a. Leadership team will be inserviced on 7/15/21 that no employee can start or fill-out new-hire paperwork until they have been cleared through the healthcare registry. b. HR/Operations manager is the double-check system, and will not fill out new hire paperwork or let an employee start without checking the healthcare registry. Inservice on this information will be completed on 7/15/21. 7. 10A NCAC 27E.0107 Training on Alternatives to Restrictive Interventions (V536): a. Audit will be completed including all staff who are fully trained in CPI (Crisis Prevention Intervention). Staff who are not current in CPI training will not be allowed to provide direct supervision for students until re-certified. Audit will be completed by 7/16/21. b. Once all staff are trained, an audit of CPI trained staff will be added to CQAC (Compliance and Quality Assurance Committee) meetings monthly. 8. 10A NCAC 27E.0108 Training in Seclusion,	V 179		

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V 179	Continued From page 48 Physical Restraint and Isolation Time-Out (V537): a. HR/Operations manager, Program Director, Clinical Director, Executive Director and CPI Trainer will be inserviced on 7/23/21 on the documentation that is required for Seclusion, Physical Restraint and Isolation Time-Out training, including: i. Who participated in the training and the outcomes (pass/fail); ii. When and where they attended; iii. Instructor's name; and iv. Service providers shall maintain documentation of initial and refresher training for at least three years. 9. 10A NCAC 27G.0302 Facility Construction/Alterations/Additions (V722): a. Calm room was closed on 7/9/21 and will not be used until state construction section approval has been obtained. 10. 10A NCAC 27G.0303 Location and Exterior Requirements (V736): a. Water temps will be tested weekly starting 7/19. If any temperature is out of range of 100 - 116 degrees, maintenance will address immediately. b. Weekly physical plant rounds will begin the week of 7/19 and will assess for cleanliness and any physical plant issues that are in disrepair. Upon identification, a plan will be put in place to repair. 11. 10A NCAC 27G.0304 Facility Design and Equipment (V778): a. The Equinox RTC Policy and Procedure manual has been updated to clarify that children and adolescents shall not share a bedroom with an adult. b. Residential and Clinical staff will be inserviced beginning 7/14/21 to include that 18 year olds must be in a room of their own and are only able to share a bedroom with other 18 year old	V 179		

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V 179	Continued From page 49 residents. 12. All above Tags are crossed into 10A NCAC 27G.1301 Scope (V179) for Type A1 Administrative Action: a. New HR/Operations Manager started 6/30/21. Training will include proper maintenance of employee files. b. New Clinical Director and Program Director start 7/19/21. They will review Equinox Policies and Procedures against state regulations pertaining to .1300 Residential Treatment and make suggestions for updates, as needed, by 7/28/21. Describe your plans to make sure the above happens. 1. A CQAC meeting will be held for each area not in compliance. The CQAC committee will decide whether audits are completed daily, weekly, monthly, etc. The next CQAC meeting will be held on 7/20/21. Then, recommendation will be sent to the Governing Body for approval on 7/22/21. 2. The above plans will be implemented until sufficient compliance is met and maintained as determined by the Governing Body." Clients served by the facility had a range of mental health diagnoses including but not limited to Generalized Anxiety Disorder, Dysthymic Disorder, Major Depressive Disorder, Unspecified Trauma and Stressor Related Disorder, Adjustment Disorder, Oppositional Defiant Disorder (ODD); Attention-Deficit Hyperactivity Disorder (ADHD) and Parent-Child Relational Problems. Clients ranged in age from 14 - 18 years old and had histories of trauma, sexualized behaviors, self-injurious behaviors, elopements, substance abuse and suicide attempts. The facility failed to train the appropriate number of staff in CPR/First Aid and in Medication Administration to meet the needs of the clients.	V 179		

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V 179	Continued From page 50 Between 4/14/21 and 7/3/21, there were 46 overnight shifts in which there were no CPR certified staff on campus and there were 56 overnight shifts in which there were no staff members on campus who were trained to administer medications. Staff could not support a client's request for ibuprofen when he cut the inside of his lip on 6/12/21 and could not support a client's request for congestion medication on 6/24/21. Furthermore, there was a staff member (Staff #11) who was administering medications to clients without any documentation of having received medication administration training. Between April 2021 - June 2021, Staff #11 administered a total of 201 doses of medication, effecting 4 clients. The facility hired 7 of 36 audited current staff and 1 of 4 audited former staff prior to accessing the HCPR Registry. 21 of 36 audited current staff members were not trained in Alternatives to Restrictive Interventions, or trained in Seclusion, Physical Restraint and Isolation Time-Out prior to providing services to clients. Additionally, there was no documentation of Client Specific training for 33 of 36 audited current staff. The facility was re-cited for failure to maintain the grounds in a safe, clean, attractive and orderly manner. One bathroom was clogged with feces and the bathrooms beside the dining hall were out of order. There was a 2-3 inch hole in the dining room floor which went through the sub-floor exposing the ground below and there were numerous other maintenance and safety concerns. The facility failed to consult with construction prior to using a room with alterations. Plexiglass had been installed to cover the window in the room which left no direct egress if the room door was blocked. Facility fire and disaster drills were not completed quarterly as required. Therapist #1 and Therapist #2 failed to demonstrate competency by not having goals and	V 179		

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V 179	Continued From page 51 strategies on the treatment plans to address clients' identified behavior issues. The facility allowed adults and minors to share a bedroom. FC #8 was 18 years old and was alleged to have sexual encounters with several of the younger clients and the facility failed to provide interventions to address the sexual encounters and failed to implement safety measures to prevent them from re-occurring. The RN failed to demonstrate competency by throwing away certifications of staff medication administration training; by allowing her own CPR/First Aid certification to lapse between 2/12/21 and 3/30/21 and by creating an electronic account for Staff #11 to administer medications without proper documentation of training. The Executive Director failed to demonstrate competency by not providing oversight to ensure the facility followed NC State Licensure requirements as indicated in the ED's job description. This deficiency constitutes a Type A1 rule violation for serious 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 compliance beyond the 23rd day.	V 179		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC	V 512		

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V 512	Continued From page 52 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews and interviews, the Registered Nurse (RN) subjected 2 of 5 audited former clients (FC #9 and FC #10) to neglect and the Executive Director (ED) subjected 12 of 12 current clients to exploitation. The findings are: Finding #1 Review on 6/28/21 of the RN's record revealed: -A hire date of 5/22/19. -Licensed as an RN since 2007. -Licensed as an RN in the State of NC 5/28/21-8/31/22. Review on 7/8/21 of the RN's Job Description revealed: -One of the RN's responsibilities was to oversee and manage the "needs of ill students, asses and diagnose the nature of illnesses and the need for implementation of sickbed policy and/or outside	V 512		

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V 512	Continued From page 53 medical treatment". Review on 7/8/21 of FC #9's record revealed: -Date of Admission: 4/21/20. -Age: 18. -Discharged: 4/14/21. Review on 7/2/21 of a Local Hospital Emergency Department Note for FC #9 revealed: -FC #9 was triaged in the emergency department at 11:00 pm on 8/25/21. -FC #9 reported he was hit in the head with a skateboard at approximately 5:30 pm on 8/25/21. -No evidence was presented during the survey to indicate what measure the facility put in place during the above time frame. -FC #9 had a laceration to his scalp and 6 staples were used to close the wound. Review on 7/8/21 of FC #10's record revealed: -Date of Admission: 3/23/20. -Age: 16. -Discharged: 6/14/21. Interview on 7/6/21 with FC #10 revealed: -He had never been taken less seriously for injuries in his life. -He injured his hand and it took several weeks before it was x-rayed. -He also broke his collar bone and the nurse evaluated him and said it was fine. -He called his parents and informed them that something was wrong and that staff refused to take him to the hospital. -Every time he sat up, he would have shooting pain in his body. -He stated, "I knew something was wrong ...I would need help because one arm was in a sling ...help getting up in bunk. I couldn't do the dishes ...I couldn't move my arm ..."	V 512		

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V 512	Continued From page 54 -He was accused of "pain manipulation" by staff. Interview on 7/7/21 with the RN revealed: -When FC #10 injured his collarbone, she made the decision to ice it and give him pain medication. -FC #10's family told her "to just assess, just to watch and determine if he needed to be seen (by a doctor) ..." -The RN assessed FC #10 for several days and he continued to complain of pain. -FC #10 was eventually taken to urgent care to be seen by a doctor and was diagnosed with a fractured collarbone. -She believed she did the right thing by asking FC #10's Mother to determine if he needed to be taken to a doctor. -She stated, "I should be more proactive at saying a kid needs to be seen ...It's the gray areas where we don't know for sure that we should just take them (clients) to be seen. I don't step out of the boundaries and send a kid anyway if the parent doesn't want a kid to be sent out for medical care ..." -When FC #10 injured his hand/thumb while skiing, "it was pretty much the same protocol ... letting Mom know and watching." -She did not remember the time frame from FC #10's hand/thumb injury to going to urgent care. -FC #10 was sent to an Orthopedic Surgeon after being seen at urgent care. -She stated, " ...I don't know if they noticed a fracture but they splinted it and treated it and told him (FC #10) not to do activities and then they ordered an MRI. I was out on leave so I'm not sure what the findings were." -If the RN is not on site when an incident occurs, the mentor would notify the shift coordinator and the shift coordinator would contact the RN and describe the injury. If there was a visible injury,	V 512		

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staff would send a picture of the injury to the RN and the RN would determine if the client needed to go to urgent care.
-When FC #9 was hit over the head with a skateboard, she was on call and staff sent her a photo of his injury.
-She stated, "He (FC #9) had an open cut on his head. I called the direct care staff because it is hard to tell from photos and I asked them what they thought of his wound. I asked if it could wait until I came in the next day. They said it looked like it needed to be addressed. They have first aid training, or I believe so."
-There was a delay in taking FC #9 to the emergency room because it took time for the RN to speak with family and staff.
-FC #9's head wound required stitches.
-There had been times when there was not enough staff on campus to send a client to urgent care, "but we could always call in an extra staff member to be able to send them."
-She was going to start "using best practice instead of relying on what each parent wants done."

Interview on 7/9/21 with the Executive Director revealed:
-FC #10 was taken to urgent care several days after his injury occurred and it was confirmed that FC #10 had a broken bone.

Review on 7/7/21 of the facility's Admissions Agreement revealed:
-"The sponsors, simultaneous with the execution of this Admissions Agreement, shall appoint Equinox at the student's true and lawful attorney for the purpose of providing custodial care and educational and clinical services. The Power of Attorney shall be in effect until the student's discharge from Equinox. The sponsors must sign

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V 512	Continued From page 56 Power of Attorney at or before the time of admission." Review on 7/7/21 of Equinox RTC Policy #5.8 Medical Emergency Procedure dated 1/1/17 with a review date of 3/9/21 revealed: -"In the event that a resident is injured at Equinox, or during an Equinox activity, and the injury requires more than basic first aid (As defined in Appendix C), up to and including emergent medical attention, the following procedure has been developed to confirm appropriate care is provided. When a resident is injured or hurt onsite, or during an offsite Equinox activity, and the Equinox nurse is not present at the site; A. The Mentor will: Assess the injury or condition and determine the level of care that seems appropriate Call the Equinox Nurse for direction and/or confirmation of appropriate care. If outside medical attention is necessary, decide who should transport the resident to the medical center (Nurse, Mentor, or EMT (Emergency Medical Technician)). If an EMT is necessary, the mentor will call 911. Determine who should accompany the resident to the medical center with the EMT. The nurse or designee will call the therapist to inform them and determine procedure for informing parents of the resident's injury. Follow direction given from the primary therapist. If primary therapist is not available, call the Clinical Director, and then the Executive Director. The TM (Team Manager) will then call the Recreation Director, if the injury happened during a recreation activity under their direction. Retrieve the resident's personal info and medical insurance information (Travel Pack) from the filing cabinet in the med room and take that	V 512		

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information to the medical center with the resident.
The Mentor assigned should be the staff transporting the resident to the medical facility.
Equinox staff will remain with the resident at the medical facility until discharged.
I 0. Once at the medical center, provide the insurance and personal information to the medical professionals.
Once the resident is under the care of the medical personnel at the health care facility, call the nurse to keep them informed of the process.
Nurse or therapist will update the guardians as needed.
When the resident is fully diagnosed and treated, nurse will update guardians with details of visit.
Receive any follow up treatment recommendations, and/or prescriptions for the resident from the medical provider and bring those with you back to the facility.
Call the Equinox nurse again to inform them of the treatment recommendations and/or prescriptions provided.
Follow the directions from the nurse in carrying out the recommendations. This may include going to the pharmacy to pick up the prescribed medications and administering medications as prescribed.
When a resident is injured or hurt onsite, or during an offsite Equinox activity, and the Equinox nurse is present at the site, the following procedure will be followed:
A. The Equinox Nurse will:
Assess the nature of the injury/condition and determine level of care needed.
If outside medical attention is necessary, decide who should transport the resident to the medical center (Nurse, Mentor, or EMT).
If an EMT is necessary direct staff to call 911 .
Determine who should accompany the resident to

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the medical center with the EMT.
If a Mentor will be transporting resident, direct them to follow the procedure outlined below in 2 B.
Nurse will notify the Therapist.
Notify Executive Director if hospitalization is required.
Call the Team Manager to inform them of the incident.
Call the parents to inform them of the incident and the treatment plan.
Once treatment and recommendations for follow up are given by medical provider call parents again to support and answer any questions or concerns ..."

Finding #2
Interview on 7/6/21 with FC#10's legal guardian revealed:
-she thought she might get a call from DHSR surveyors;
-she reported being actively involved in FC#10's treatment;
-she confirmed that she had to sign a non-disparagement agreement regarding the facility and was concerned about saying disparaging remarks about the facility;

Review on 7/7/21 of the facility's non-disparagement agreement revealed:
-a document that the facility has legal guardians sign during admission of clients agreeing that legal guardians nor their family members, friends, or associates will not say anything negative about the facility or risk legal action;
-the document states, "legal guardian/parent agree that they will not publicly criticize, ridicule, defame, or disparage Equinox or its conduct, services, practices, policies, facilities, personnel, management, directors, officers, or otherwise

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communicate about Equinox, its conduct, services, practices, policies, facilities, personnel, management, affiliates, directors, or officers in a disparaging or negative manner in any medium (including online or through social media) to any person or entity without limitation in time ...Parents/Custodian further agree to not encourage family members, friends, agents or other third parties from, and shall take any and all reasonable steps to prevent or persuade others with whom they have familial or social relationships from, any public criticism, ridicule, defamation, or disparagement of Equinox, its conduct, its practices, services policies, facilities, personnel, management, affiliates, directors, or officers. The Parties to this agreement agree and acknowledge that this non-disparagement provision is a material term of this Agreement, the absence of which would have resulted in Equinox declining to enter into this agreement ....Parent/Guardian further agree and acknowledge that damages arising from breach of this provision may be difficult to identify and that the potential harms arising from such a breach are likely to be of an ongoing nature, cannot reasonably or adequately be compensated by damages in any action at law, and constitute irreparable injury or damage ... Therefore, Parents/Custodians expressly agree and acknowledge that Equinox shall be entitled to seek and obtain injunctive relief in the event of, or to prevent, any breach of this non-disparagement provision by Parents/Custodians or third parties ...In the event of a violation of this non-disparagement provision by Parents/Custodians or third parties, Equinox shall also have the right to monetary relief, and recovery of reasonable attorney fees and costs incurred in seeking either monetary or injunctive relief, regardless of the number or instances of

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V 512	Continued From page 60 alleged breaches of this agreement." Interview on 7-9-21 with the Executive Director revealed: The purpose of the non-disparagement agreement is to request families to bring concerns to us as a program so we can seek to provide solutions and address concerns in a productive and healthy manner. "I believe that in the current climate of the world we live in right now...working with clients and families that have a variety of emotional challenges there is a need to create some boundary lines to invite them to address concerns and challenges in appropriate way with program management. " The use of a non-disparagement agreement by the ED breached the duty of care requirement. Requiring guardians to sign the agreement in order to obtain needed residential services for their child violated the client and family's rights as guaranteed in G.S. 122C-62. The right to raise concerns regarding their child's treatment and consult with outside parties limits the guardian's ability to secure and ensure effective treatment. The non-disparagement agreement in use by Equinox is outside the applicable standards of practice for licensed mental health providers and public policy. Review on 7/14/21 of the Plan of Protection (POP) dated and signed by the Owner (Business Development Director/Admissions Director) on 7/14/21 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 10A NCAC 27D.0304 Protection from Harm, Abuse, Neglect or Exploitation (V512): a. Identified staff will receive counseling from HR (Human Resource) Department or Governing body with input from licensed Rn (from outside of	V 512		

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V 512	Continued From page 61 Equinox RTC) on noted discrepancies. They will be provided with ongoing training in identified areas by 7/23/21. b. The Governing Body (including Owner; Academic Director; Clinical Director; Program Director; HR/Operations Manager) will assess identified staff for job performance and needs for training on a monthly basis. The next Governing Body Meeting will take place on 7/22/21. c. RN will be counseled on 7/14. They will be inserviced that Equinox has approval at admission for clients to be seen by a medical provider based on program staff's observation of the client, and that no delay needs to occur if parents/guardians are not responsive to communications from program staff. Further, they will be counseled to seek immediate medical attention if assessments cannot provide a conclusive determination that an injury has not occurred. Describe your plans to make sure the above happens. 1. A CQAC (Compliance Quality Assurance Committee) meeting will be held for each area not in compliance. The CQAC committee will decide whether audits are completed daily, weekly, monthly etc. The next CQAC meeting will be held on 7/20/21. Then, recommendation will be sent to the Governing Body for approval on 7/22/21. 2. The above plans will be implemented until sufficient compliance is met and maintained as determined by the Governing Body." Review on 8/9/21 of the Plan of Protection (POP) dated and signed by the Owner (Business Development Director/Admissions Director) on 8/9/21 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care?	V 512		

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V 512	Continued From page 62 10A NCAC 27D.0304 Protection from Harm, Abuse, Neglect or Exploitation (V512): 1. The non-disparagement agreement previously included in the Equinox RTC enrollment documents has been removed as of 8/9/21. 2. The non-disparagement agreement signed by families of current clients has been removed from their files as of 8/9/21 and families will be alerted as of 8/9/21 that the document has been removed from their file and destroyed. 3. Equinox will not enforce the non-disparagement agreement moving forward or backward for current or past families who have signed it. Describe your plans to make sure the above happens: 1. See above." The facility served male clients who ranged in age from 14 - 18 years old. Clients residing at the facility had a range of mental health diagnoses including but not limited to Generalized Anxiety Disorder, Dysthymic Disorder, Major Depressive Disorder, Unspecified Trauma and Stressor Related Disorder, Adjustment Disorder, Oppositional Defiant Disorder (ODD); Attention-Deficit Hyperactivity Disorder (ADHD) and Parent-Child Relational Problems. The Registered Nurse was employed by the facility to oversee issues related to the physical health and medical needs of the clients. The RN subjected FC #9 and FC #10 to neglect by delaying medical treatment. The RN failed to recognize when there was a need for further diagnostic testing and medical intervention by a doctor. She relied on the client's parents who were not on site, or on direct care staff who were not medically trained to determine what type of treatment FC #9 and FC #10 needed. When FC #9 sustained a laceration to his head which warranted staples, he was not	V 512		

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V 512	Continued From page 63 taken to the emergency room immediately. The RN caused several hours of delay in treatment by waiting to get verbal consent from FC #9's parents. The facility obtained a Power of Attorney for each client upon admission which allowed facility staff to seek medical treatment for each client in the event of an illness, or injury. Facility policy indicated that it was the responsibility of the RN to determine the level of medical care needed for each client's condition. The RN failed to follow facility policy and failed to have emergent care provided to FC #9 for 5 1/2 hours. Furthermore, when FC #10 fractured his collarbone and reported to the RN that he was in pain, the RN neglected to send him to urgent care for several days. Additionally, when FC #10 injured his hand/thumb in a separate incident, there was also a delay in seeking medical treatment. The requirement of acceptance and signature of the non-disparagement agreement upon admission to the treatment program is a violation of the fiduciary relationship between the facility and the client and family and constitutes exploitation. As demonstrated, it had a chilling effect on the legal guardian of Client #10 freely sharing information with surveyors. The non-disparagement agreement violates the rights of clients and families to disclose information during a survey as guaranteed in General Statute (G.S) 122C-25. It further violates the right to communicate and consult with other mental health professionals, legal counsel, advocates and others under G.S. 122C-62. This deficiency constitutes a Type A1 rule violation for serious neglect and exploitation 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	V 512		

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V 512	Continued From page 64 day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the	V 536		

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V 536	Continued From page 65 following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program	V 536		

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V 536	Continued From page 66	V 536		

aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the

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V 536	Continued From page 67 outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure 21 of 36 audited current staff (Staff #1, #3, #6, #7, #8, #12, #13, #14, #15, #16, #17, #18, #21, #22, #24, #25, #26, #27, #28, #31 and #32) had training in alternatives to restrictive interventions prior to providing services. The findings are: Review on 6/28/21 and 7/14/21 of Staff #1's record revealed: -A hire date of 9/14/20. -Documentation that Crisis Prevention Intervention (CPI) training was completed on 10/9/20. Review on 6/28/21 and 7/14/21 of Staff #3's	V 536		

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record revealed:
-A hire date of 11/29/18.
-Documentation that CPI certification expired on 12/20/20 and was not renewed until 1/5/21.

Review on 6/28/21 and 7/14/21 of Staff #6's record revealed:
-A hire date of 6/21/21.
-There was no evidence that training in alternatives to restrictive interventions had been completed.

Review on 6/28/21 and 7/14/21 of Staff #7's record revealed:
-A hire date of 1/28/19.
-Documentation that CPI certification expired on 1/31/21 and was not renewed until 2/12/21.

Review on 6/28/21 and 7/14/21 of Staff #8's record revealed:
-A hire date of 2/1/21.
-Documentation that CPI training was completed on 3/11/21.

Review on 6/28/21 and 7/14/21 of Staff #12's record revealed:
-A hire date of 6/6/19.
-Documentation that CPI certification expired on 6/5/21 and was not renewed until 6/11/21.

Review on 6/28/21 and 7/14/21 of Staff #13's record revealed:
-A hire date of 9/28/20.
-Documentation that CPI training was completed on 10/9/20.

Review on 6/28/21 and 7/14/21 of Staff #14's record revealed:
-A hire date of 3/2/20.
-There was no evidence of initial CPI training until

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V 536	Continued From page 69 5/13/20. -Documentation that CPI certification expired on 5/13/21 and was not renewed until 5/28/21. Review on 6/28/21 and 7/14/21 of Staff #15's record revealed: -A hire date of 8/31/20. -Documentation that CPI training was completed on 9/11/20. Review on 6/28/21 and 7/14/21 of Staff #16's record revealed: -A hire date of 2/1/21. -Documentation that CPI training was completed on 2/11/21. Review on 6/28/21 and 7/14/21 of Staff #17's record revealed: -A hire date of 5/26/21. -Documentation that CPI training was completed on 6/10/21. Review on 6/28/21 and 7/14/21 of Staff #18's record revealed: -A hire date of 9/28/20. -Documentation that CPI training was completed on 10/9/20. Review on 6/28/21 and 7/14/21 of Staff #21's record revealed: -A hire date of 9/28/20. -Documentation that CPI training was completed on 10/9/20. Review on 6/28/21 and 7/14/21 of Staff #22's record revealed: -A hire date of 6/16/20. -CPI certification expired 6/5/20. -There was no documentation of current certification in alternatives to restrictive	V 536		

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V 536	Continued From page 70 intervention training. Review on 6/28/21 and 7/14/21 of Staff #24's record revealed: -A hire date of 4/5/21. -Documentation that CPI training was completed on 4/29/21. Review on 6/28/21 and 7/14/21 of Staff #25's record revealed: -A hire date of 3/1/18. -There was no evidence of initial CPI training until 8/21/20. Review on 6/28/21 and 7/14/21 of Staff #26's record revealed: -A hire date of 8/31/20. -Documentation that CPI training was completed on 9/11/20. Review on 6/28/21 and 7/14/21 of Staff #27's record revealed: -A hire date of 7/27/20. -Documentation that CPI training was completed on 9/11/20. Review on 6/28/21 and 7/14/21 of Staff #28's record revealed: -A hire date of 4/12/18. -Documentation that CPI certification expired on 4/26/20 and was not renewed until 11/20/20. Review on 6/28/21 and 7/14/21 of Staff #31's record revealed: -A hire date of 6/2/21. -Documentation that CPI training was completed on 6/10/21. Review on 6/28/21 and 7/14/21 of Staff #32's record revealed:	V 536		

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V 536	Continued From page 71 -A hire date of 10/12/20. -Documentation that CPI training was completed on 10/23/20. Review on 6/29/21 of the AM and PM schedule for facility staff from 4/14/21 through 7/3/21 revealed: -Staff #24 worked 4/24/21 prior to being certified in CPI on 4/29/21. Review on 6/29/21 of the overnight schedule for facility staff from 4/14/21 through 7/3/21 revealed: -Staff #17 shadowed on night shift 5/27/21 and 5/29/21 and was then worked on night shift 5/30/21, 5/31/21, 6/5/21, 6/6/21, 6/7/21, and 6/8/21 prior to being certified in CPI on 6/10/21. -Staff #31 shadowed on night shift 6/3/21 and was then worked on night shift 6/4/21, 6/6/21 and 6/7/21 prior to being certified in CPI on 6/10/21. Interview on 7/9/21 with the Executive Director (ED) revealed: -The Human Resource (HR) Operations Manager, the Program Director, the Clinical Director and the Executive Director shared the responsibility of ensuring that all staff were adequately trained. -The process for auditing staff records was changed during the COVID 19 pandemic. -Records were audited virtually and "items were missed." -He stated, "So as the Executive Director, all responsibility rolls up to me and I personally take accountability for not recognizing that our audit system was not adequate." -A new HR Operations Manager was recently hired and new processes would be put in place to make sure files are appropriately maintained. This deficiency is cross referenced into 10A	V 536		

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V 536	Continued From page 72 NCAC 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually).	V 537		

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V 537	Continued From page 73 (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements:	V 537		

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V 537	Continued From page 74 (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the	V 537		

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V 537	Continued From page 75 coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure 21 of 36 audited current staff (Staff #1, #3, #6, #7, #8, #12, #13, #14, #15, #16, #17, #18, #21, #22, #24, #25, #26, #27, #28, #31 and #32) had training in the use of seclusion, physical restraints and isolation time out prior to providing services. The findings are:	V 537		

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V 537	Continued From page 76 Review on 7/8/21 of Equinox Policy #4.4 Restrictive Interventions dated 1/1/17 revealed: -"At Equinox, Restrictive Interventions may be employed in emergency situations in order to effectively manage a behavior or action in which a resident is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others." -"After emergency usage of Restrictive Interventions have occurred, the therapist may determine that it is necessary to incorporate these interventions into the resident's Master Treatment Plan as a planned measure of therapeutic treatment." Review on 6/28/21 and 7/14/21 of Staff #1's record revealed: -A hire date of 9/14/20. -Documentation that Crisis Prevention Intervention (CPI) training was completed on 10/9/20. Review on 6/28/21 and 7/14/21 of Staff #3's record revealed: -A hire date of 11/29/18. -Documentation that CPI certification expired on 12/20/20 and was not renewed until 1/5/21. Review on 6/28/21 and 7/14/21 of Staff #6's record revealed: -A hire date of 6/21/21. -There was no evidence that restrictive intervention training had been completed. Review on 6/28/21 and 7/14/21 of Staff #7's record revealed: -A hire date of 1/28/19. -Documentation that CPI certification expired on 1/31/21 and was not renewed until 2/12/21.	V 537		

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V 537	Continued From page 77 Review on 6/28/21 and 7/14/21 of Staff #8's record revealed: -A hire date of 2/1/21. -Documentation that CPI training was completed on 3/11/21. Review on 6/28/21 and 7/14/21 of Staff #12's record revealed: -A hire date of 6/6/19. -Documentation that CPI certification expired on 6/5/21 and was not renewed until 6/11/21. Review on 6/28/21 and 7/14/21 of Staff #13's record revealed: -A hire date of 9/28/20. -Documentation that CPI training was completed on 10/9/20. Review on 6/28/21 and 7/14/21 of Staff #14's record revealed: -A hire date of 3/2/20. -There was no evidence of initial CPI training until 5/13/20. -Documentation that CPI certification expired on 5/13/21 and was not renewed until 5/28/21. Review on 6/28/21 and 7/14/21 of Staff #15's record revealed: -A hire date of 8/31/20. -Documentation that CPI training was completed on 9/11/20. Review on 6/28/21 and 7/14/21 of Staff #16's record revealed: -A hire date of 2/1/21. -Documentation that CPI training was completed on 2/11/21. Review on 6/28/21 and 7/14/21 of Staff #17's	V 537		

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V 537	Continued From page 78	V 537		

record revealed:
-A hire date of 5/26/21.
-Documentation that CPI training was completed on 6/10/21.

Review on 6/28/21 and 7/14/21 of Staff #18's record revealed:
-A hire date of 9/28/20.
-Documentation that CPI training was completed on 10/9/20.

Review on 6/28/21 and 7/14/21 of Staff #21's record revealed:
-A hire date of 9/28/20.
-Documentation that CPI training was completed on 10/9/20.

Review on 6/28/21 and 7/14/21 of Staff #22's record revealed:
-A hire date of 6/16/20.
-CPI certification expired 6/5/20.
-There was no documentation of current certification in restrictive intervention training.

Review on 6/28/21 and 7/14/21 of Staff #24's record revealed:
-A hire date of 4/5/21.
-Documentation that CPI training was completed on 4/29/21.

Review on 6/28/21 and 7/14/21 of Staff #25's record revealed:
-A hire date of 3/1/18.
-There was no evidence of initial CPI training until 8/21/20.

Review on 6/28/21 and 7/14/21 of Staff #26's record revealed:
-A hire date of 8/31/20.
-Documentation that CPI training was completed

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V 537	Continued From page 79 on 9/11/20. Review on 6/28/21 and 7/14/21 of Staff #27's record revealed: -A hire date of 7/27/20. -Documentation that CPI training was completed on 9/11/20. Review on 6/28/21 and 7/14/21 of Staff #28's record revealed: -A hire date of 4/12/18. -Documentation that CPI certification expired on 4/26/20 and was not renewed until 11/20/20. Review on 6/28/21 and 7/14/21 of Staff #31's record revealed: -A hire date of 6/2/21. -Documentation that CPI training was completed on 6/10/21. Review on 6/28/21 and 7/14/21 of Staff #32's record revealed: -A hire date of 10/12/20. -Documentation that CPI training was completed on 10/23/20. Review on 6/29/21 of the AM and PM schedule for facility staff from 4/14/21 through 7/3/21 revealed: -Staff #24 worked 4/24/21 prior to being certified in CPI on 4/29/21. Review on 6/29/21 of the overnight schedule for facility staff from 4/14/21 through 7/3/21 revealed: -Staff #17 shadowed on night shift 5/27/21 and 5/29/21 and was then worked on night shift 5/30/21, 5/31/21, 6/5/21, 6/6/21, 6/7/21, and 6/8/21 prior to being certified in CPI on 6/10/21. -Staff #31 shadowed on night shift 6/3/21 and was then worked on night shift 6/4/21, 6/6/21 and	V 537		

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V 537	Continued From page 80 6/7/21 prior to being certified in CPI on 6/10/21. Interview on 7/9/21 with the Executive Director (ED) revealed: -The Human Resource (HR) Operations Manager, the Program Director, the Clinical Director and the Executive Director shared the responsibility of ensuring that all staff were adequately trained. -The process for auditing staff records was changed during the COVID 19 pandemic. -Records were audited virtually and "items were missed." -He stated, "So as the Executive Director, all responsibility rolls up to me and I personally take accountability for not recognizing that our audit system was not adequate." -A new HR Operations Manager was recently hired and new processes would be put in place to make sure files are appropriately maintained. This deficiency is cross referenced into 10A NCAC 27G.1301 Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.	V 537		
V 722	27G .0302 (a) DHSR Construction Approval 10A NCAC 27G .0302 FACILITY CONSTRUCTION/ALTERATIONS/ ADDITIONS (a) When construction, use, alterations or additions are planned for a new or existing facility, work shall not begin until after consultation with the DHSR Construction Section and with the local building and fire officials having jurisdiction. Governing bodies are encouraged to consult with DHSR prior to purchasing property intended for use as a facility. This Rule is not met as evidenced by:	V 722		

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V 722	Continued From page 81 Based on observation, interview and record review, the facility failed to consult with the DHSR Construction Section prior to additions made to the facility (Spring Dorm). The findings are: Observation of facility on 6/24/21 at 10:40am revealed: -surveyors #1 and #3 observed additions to the Refocus Room (secluded time out room) in Spring Dorm that was being built during the last survey in March 2021; -surveyors #1 and #3 observed a brown chair in the room with a blue blanket, white noise machine, decals on the wall, recessed lighting and an area rug; -surveyors #1 and #3 observed panes around the windows that were unfinished wood; -surveyors #1 and #3 observed plexiglass covering both windows in the room, leaving no egress. Interview on 6/24/21 with Executive Director revealed: -the facility is using this space as a "Calm Room" and not a "Re-Focus Room." -one client had utilized the room since March 30th, 2021; Interview on 6/24/21 and 6/28/21 with Client#4 revealed: -he confirmed that he had spent time in the Calm Room; -he was given the choice to go to the Calm Room after running away or be separated from the milieu elsewhere; -he was in the Calm Room for a few hours until facility staff told him he could go to the dining hall for dinner. Interview on 7/2/21 with DHSR Construction	V 722		

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V 722	Continued From page 82 Section staff revealed: -they just assigned the project for Equinox today; -they sent the ED a letter on 6/15/21 with floor plan receipts and received payment on 6/29/21. Review on 7/6/21 of email dated 7/6/21 from DHSR Construction at 9:40am revealed: -the project at the facility had neither been reviewed or approved at this point. Interview on 7/9/21 with Executive Director (ED) revealed: -during the last survey it was brought to his attention that an application had not been submitted and the facility began discussing plans with construction; -the Acting Chief for the Division of Health Service Regulation and Western Branch Manager came on site to the facility and observed the addition in person; -ED reported that the Acting Chief and Western Branch Manager told him to use the room as a Calm Room instead of a Refocus Room and thought verbal approval was given; -he reported he misunderstood comments made by the Section Chief and Western Branch Manager; -he will make staff aware immediately that the room cannot be used until approved by construction. This deficiency constitutes a recited deficiency and is cross referenced in to 10A NCAC 27G .1301 Scope (V179) for Type A1 rule violation and must be corrected within 23 days.	V 722		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND	V 736		

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V 736	Continued From page 83 EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain the facility and grounds in a safe, clean, attractive, and orderly manner. The findings are: Observation on 6/24/21 at 10:45am and Interview with Executive Director (ED) revealed: -Surveyors #1 & #3 observed both client dorms (Winter and Spring Dorm) and facility grounds including the gymnasium, dining hall, school and clinical building; -Clients were being housed in Winter Dorm (Cloud/Fog) only during this survey; -ED reported that clients had moved to Winter Dorm approximately 3-4 weeks ago; -all three bathrooms upstairs in Winter Dorm (Cloud) registered at 120 degrees for water temperature; -a sink faucet was visibly loose in upstairs bathroom in Winter Dorm (Cloud); -downstairs in Winter Dorm (Fog), the first bedroom to the right was missing a vent plate cover in the ceiling; -between the largest bedroom and bathroom in Fog, there was a transition piece missing in the floor; a screw was sticking up and upon further observation revealed a nail sticking out during walk through; -in the hallway behind client bedrooms a door to	V 736		

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V 736	Continued From page 84 the outside had hardware remnants from blinds sticking out, approximately 4 pieces; -in spring dorm (Eagles Nest), the second bathroom down the hall had peeling drywall above the shower; -the window outside of the second bedroom in Eagles Nest was taped on the outside due to a crack in the window; -the dining hall had a hole in floor approximately 2-3 inches in diameter that exposed the subfloor all the way to the ground; -the hole was near the entrance to the building and adjacent to the main interior/exterior wall; -the bathroom under the gymnasium for students was clogged with feces and had toilet paper everywhere; -the bathrooms by the dining hall were closed due to being out of order; Review on 6/29/21 of email dated 6/29/21 at 3:16pm, sent to Surveyors #1, #2, #3 from the Executive Director (ED) revealed: -updated image of transition piece in floor between the bathroom and bedroom in Winter Dorm (Fog) that had been fixed since walk through on 6/24/21; Interview on 7/7/21 with Staff #3 revealed: -the students deep clean once a week and "if staff are doing their jobs it should be checked ....they monitor the cleaning." Interview on 7/9/21 with Executive Director (ED) revealed: -since the prior survey, the facility instituted walk throughs by our daily managers and for them to make notes of areas that need more attention. This deficiency constitutes a recited deficiency and is cross referenced in to 10A NCAC 27 G	V 736		

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V 736	Continued From page 85 .1301 Scope (V179) for Type A1 rule violation and must be corrected within 23 days.	V 736		
V 778	27G .0304(d)(9) Occupany Age Restrictions 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (9) Children and adolescents shall not share a bedroom with an adult. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that children and adolescents did not share a bedroom with an adult affecting 4 of 5 audited current clients, (Clients #1, #2, #4, #5) and 3 of 5 audited former clients (FC #7, FC#8, FC#10), and 11 non-audited former clients. The findings are: Review on 6/29/21 of Client#1's record revealed: -date of admission: 10/30/20; -18 year-old; -resided in Spring and Winter Dorm Review on 6/28/21 of Client #2's record revealed: -date of admission: 06/04/2020 -15 year-old; -resided in Spring and Winter Dorm Review on 7/7/21 of Client #4's record revealed:	V 778		

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V 778	Continued From page 86 -date of admission: 3/15/21 -14 year-old; -resided in Spring and Winter Dorm Review on 7/8/21 of Client #5's record revealed: -date of admission: 10/26/20 -17 year-old; -resided in Winter Dorm Review on 7/1/21 of FC#7's record revealed: -date of admission: 02/01/21 -date of discharge: 3/24/21 -15 year-old; -resided in Spring Dorm Review on 7/7/21 of Former Client #8's record revealed: -date of admission: 01/14/20 -date of discharge: 03/25/21 -18 year-old; -resided in Winter Dorm Review on 7/8/21 of FC#10's record revealed: -date of admission: 03/23/20 -date of discharge: 06/14/2021 -16 year-old; -resided in Winter Dorm Review on 6/29/21 and 7/1/21 of facility's overnight/awake shift notes from 3/1/21 to 3/31/21 and 4/24/21 to 06/27/21 revealed: -the clients were housed in two dorms: Winter and Spring Dorms until 5/13/21; -after 5/13/21, all of the clients were housed together in 2 floors of Winter Dorm; -the top floor of Winter Dorm is Cloud and the bottom floor is Fog; -FC #8 resided in Winter Dorm (Cloud) Room 3 with two minors, a non-audited former clients (NAFC) from 3/1/21-3/24/21 and FC#10 from	V 778		

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V 778	Continued From page 87 3/1/21 to 3/15/21 intermittently; -FC#10 chose to sleep in the common area of the dorm frequently from 3/1/21-3/15/21 due to being uncomfortable with his roommate, (FC#8) and was moved to Room 1 on 3/16/21; -Client #5, a minor, who resided in Winter Dorm (Cloud), Room 2, refused to move to Room 3, after being assigned on 3/18/21,due to being uncomfortable with FC#8; -FC#8 was discharged from the facility on 3/25/21 and Client #5 moved in to Room 3. -Client #1 resided in Spring Dorm starting 3/5/21 in Room 5, with a NAFC and two other 18 year-old, NAFC's; -Client#1 was moved to the bottom of Winter Dorm (Fog) on 5/13/21 and resided in Room 1 with two minor NAFC's, and an adult NAFC until 6/3/21; -Client #4, a minor, upon admittance to the program on 3/15/21 was placed in a room with an 18 year-old NAFC and two minor NAFC's; -Client #2 and FC#7 minors, resided in Spring Dorm, Room 3 on 3/1/21 with an 18 year-old NAFC and another minor NAFC until 3/24/21 when FC#7 was discharged. Interview on 7/7/21 with staff #3 revealed: -"I don't think there is anything not allowing an 18 year-old to share a room with the other kids;" -room assignments are made by therapists and the team manager; -"18 year-olds are allowed to advocate for their own room, especially if they sign themselves back into the program." Interview on 7/12/21 with staff #5 revealed: -There wasn't a policy on 18 year-olds sharing rooms until now, (since surveyors visit) and it is no longer allowed.	V 778		

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V 778	Continued From page 88 Interview on 7/9/21 with therapist #1 revealed: -"We were told to keep kids within two years from the Executive Director, Marketing Director, and former Residential Director;" -"Legally within 3 years it is fine ...We go above and beyond." Interview on 7/9/21 with FS#30 revealed: -he was the Clinical Director of the program and left on 7/2/21; -18 years old sharing a room with minors ...."A lot of things came to light right before I left." Interview on 6/24/21 and 6/30/21 with Executive Director revealed: -he reported that he was unaware of this rule; -he reported that a prior surveyor with DHSR had approved for their 18 year-olds to be in the same room as younger adolescents and thus had operated this way for 2 years; -Surveyor #2 advised ED that surveyors cannot override a rule unless there is some type of waiver; -he reported he had email evidence to give surveyors. Review on 6/30/21 of email correspondence provided to Surveyors #1,#2 #3, dated 5/8/2019 to 5/10/2019 between the Executive Director (ED) and Operations Director at a sister facility revealed: -correspondence between the facility and a sister facility advising that a DHSR surveyor gave him approval of a policy that he, the ED, added to their policy and procedure manual to allow 18 year-olds to room with minors; -there was no staff from the Division of Health Services Regulation (DHSR) included in the email; -there was no evidence on the email that the	V 778		

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V 778	Continued From page 89 state rule had been waived by DHSR, approving 18 year-olds to room with minors; -the ED writes that "he was surprised after seeing the info that is found in the construction section ...but perhaps they (DHSR) consider the automatic waiver of an 18 year old remaining in the program as allowing them to be a full part of the program;" -the sister facility responded back to the ED quoting the rule verbatim ...and provided clarification from another section of policy regarding the difference in an "adult" client and "adolescent" (minor) client; -the operations manager advised that they (the facility) were an "adolescent program and that the ED needed to connect the two separate sections of the policies in order to understand the requirement." The email shows that the ED was aware of this rule since 2019; Interview on 7/9/21 with the Executive Director (ED) revealed: -he stopped allowing 18 year-olds to share rooms with minors ..."currently we aren't doing that;" -"In the past that would be something that would involve people ... the therapist, team manager and former DHSR surveyor based on our understanding of the acceptance that we got from former DHSR surveyor on that policy;" This deficiency is cross referenced in to 10A NCAC 27 G .1301 Scope (V179) for Type A1 rule violation and must be corrected within 23 days.	V 778		