Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		SURVEY PLETED		
		A. BOILDING.			С		
MHL047-158			B. WING			24/2021	
NAME OF F	PROVIDER OR SUPPLIER	S ⁻	TREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CANYON	I HILLS TREATMENT	FACILITY		RDEEN ROAI D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	тѕ		V 000			
A complaint survey was completed on November 24, 2021. The complaint (intake #NC00182969) was unsubstantiated and complaint (intake #NC00183490) was substantiated. A deficiency was cited.							
	This facility is licensed for the following service category: 10A NCAC 27G. 1900 PRTF-Psychiatric Residential Treatment Facility for Children and Adolescents.						
V 364	G.S. 122C- 62 Add Facilities	ditional Rights in 24 Hoບ	ır	V 364			
	§ 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by						

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		A. BUILDING:						
	MHL047-158	B. WING		11/2	; 4/2021			
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE					
CANYON HILLS TREATMENT FACILITY 769 ABERDEEN ROAD								
CANTON HILLS TREATMENT FA	RAEFORD), NC 28376						
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE			
V 364 Continued From page	1	V 364						
the client at the time of collect to the receiving (2) Receive visitors be a.m. and 9:00 p.m. for hours daily, two hours p.m.; however visiting over therapies; (3) Communicate and supervision with individupon the consent of th (4) Make visits outside unless: a. Commitment proof the result of the client's violent crime, including assault with a deadly were produced to the facilitic commitment to a correduction of Adult Correduction of Acourt order may explosited by conditions prescribed by condition	of making the call or made graphy; etween the hours of 8:00 or a period of at least six of which shall be after 6:00 shall not take precedence of meet under appropriate duals of his own choice he individuals; ethe custody of the facility deedings were initiated as as being charged with a gracime involving an	V 364						

6899

Division of Health Service Regulation STATE FORM

2HS811 If continuation sheet 2 of 7

Division	Division of Health Service Regulation							
	IT OF DEFICIENCIES		R/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFIC	CATION NUMBER:	A. BUILDING:		COMPLETED		
					С			
MHL047-158				B. WING			4/2021	
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
CANYON	HILLS TREATMENT	FACILITY		RDEEN ROAI				
07			RAEFORI	D, NC 28376				
(X4) ID		TEMENT OF DE		ID	PROVIDER'S PLAN OF CORRECTI		(X5)	
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L			PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE	
IAG	NEGOE WORLD	OO IDEITTII TIIT	5 II 11 O 1 (III)	TAG	DEFICIENCY)			
14004	<u> </u>							
V 364	Continued From pa	ge 2		V 364				
	prohibited by Chapt	ter 20 of the	General Statutes:					
	and		,					
	(10)Have access to	individual s	torage space for					
	his private use.		0 1					
	(c) In addition to th	e rights enu	merated in G.S.					
	122C-51 through G	.S. 122C-57	and G.S.					
	122C-59 through G	.S. 122C-61	, each minor client					
	who is receiving tre							
	24-hour facility has							
	proper adult superv							
	recognition of the m							
	individual, the mino							
	opportunities to ena							
	emotionally, intelled							
	vocationally. In view							
	and intellectual imm							
	24-hour facility shall		•					
	structure, supervision to the							
	the rights given to the facility shall also							
	reasonable efforts t							
	client receives treat							
	adult clients unless							
	minor client dictate		THE PRODUCT OF LITE					
	Each minor client w		ng treatment or					
	habilitation from a 2							
	(1) Communicate a							
	guardian or the age							
	custody of him;	-						
	(2) Contact and co	nsult with, a	t his own expense					
	or that of his legally							
	cost to the facility, le	egal counse	l, private					
	physicians, private							
	disabilities, or subs							
	his or his legally res							
	(3) Contact and co		client advocate, if					
	there is a client adv							
	The rights specified		-					
	restricted by the fac	cility and eac	h minor client					

6899

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					С	
		MHL047-158	B. WING			4/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		769 ARF	RDEEN ROAI			
CANYON	I HILLS TREATMENT	FACILITY	D, NC 28376			
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SO DESITIEVANCIAL INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS PEFFERNANCE TO THE APPROVI	D BE	(X5) COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIAIE	DAIL
V 364	Continued From pa	ge 3	V 364			
		rights at all reasonable times.				
		ded in subsections (e) and (h)				
		n minor client who is receiving				
		ation in a 24-hour facility has				
	the right to:	ive telephone calls. All long				
		be paid for by the client at the				
		call or made collect to the				
	receiving party;					
		ve mail and have access to				
	writing materials, po	ostage, and staff assistance				
	when necessary;					
		ate supervision, receive				
		e hours of 8:00 a.m. and 9:00				
		at least six hours daily, two				
	visiting shall not tak	I be after 6:00 p.m.; however te precedence over school or				
	therapies;					
		l education and vocational				
		ice with federal and State law;				
		daily and participate in play,				
	basis in accordance	sical exercise on a regular				
		ibited by law, keep and use				
		nd possessions under				
		sion, unless the client is being				
		apacity to proceed pursuant to				
	G.S. 15A-1002;					
	(7) Participate in re					
		individual storage space for				
		personal belongings;				
	` '	and spend a reasonable sum				
	of his own money; a					
		s license, unless otherwise er 20 of the General Statutes.				
		rated in subsections (b) or (d) be limited or restricted except				
		fessional responsible for the				
		lient's treatment or habilitation				

Division of Health Service Regulation STATE FORM

Division	of Health Service Re	egulation					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
MHL047-158			B. WING			C 11/24/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CANYON	I HILLS TREATMENT	FACILITY	RDEEN ROAI D, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 364	plan. A written state client's record that if for the restriction. The reasonable and related habilitation needs. A period not to excee each restriction shated qualified profession at which time the restriction of documented in the rights may be renew statement entered by the client's record the renewal of the restriction of a restriction of rights in each instance of of a restriction of rights the client, the legate be notified of each or renewal of a restriction of	ge 4 ement shall be placed in the indicates the detailed reason the restriction shall be ated to the client's treatment or a restriction is effective for a did 30 days. An evaluation of all be conducted by the sal at least every seven days, estriction may be removed. In a restriction shall be client's record. Restrictions on wed only by a written by the qualified professional in the states the reason for the iction. In the case of an adult been adjudicated incompetent, an initial restriction or renewal ghts, an individual designated upon the consent of the client, striction and of the reason for minor client or an incompetent ally responsible person shall instance of an initial restriction riction of rights and of the reason shall be again the client's record.	V 364				
	facility failed to ensireceive confidential	et as evidenced by: view and interviews, the ure that clients can make and telephone calls affecting 3 of 1, #2, and #3). The findings					

6899

Division of Health Service Regulation STATE FORM

If continuation sheet 5 of 7 2HS811

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 769 ABERDEEN ROAD RAFFORD, NC 28376 RABINDAMP STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION V 364 Continued From page 5 Review on 11/23/21 of Client #1's record revealed: -Admission date of 9/22/21 -Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder-combined presentation and Unspecified Trauma and Stressor Related Disorder -Current treatment plan dated 10/11/21 does not include any specifications regarding phone call parameters Review on 11/23/21 of Client #2's record revealed: -Admission date of 9/14/21 -Diagnoses of Oppositional Defiant Disorder and Post Traumatic Stress Disorder -Current treatment plan dated 10/11/21 does not include any specifications regarding phone call parameters Review on 11/23/21 of Client #3's record revealed: -Admission date of 9/29/21 -Diagnoses of Major Depressive Disorder-Recurrent, Attention Deficit Hyperactivity Disorder-Recurrent, Attention Deficit Hyperactivity Disorder-combined proster than the parameters Review on 11/23/21 of Client #3's record revealed: -Admission date of 9/29/21 -Diagnoses of Major Depressive Disorder-Recurrent, Attention Deficit Hyperactivity Disorder-combined type and Sibling relational problem -Current treatment plan dated 10/11/21 does not include any specifications regarding phone call parameters Interview on 11/23/21 with Client #1 revealed: -He did not have privacy when making telephone	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
CANYON HILLS TREATMENT FACILITY REGULATORY OR LSC DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DEFICIENCY MUST BE PRECED BY FULL TAG WE REGULATORY OR LSC DENTIFYING INFORMATION) V 364 Continued From page 5 Review on 11/23/21 of Client #1's record revealed: -Admission date of 9/22/21 -Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder-combined presentation and Unspecified Trauma and Stressor Related Disorder -Current treatment plan dated 10/11/21 does not include any specifications regarding phone call parameters Review on 11/23/21 of Client #2's record revealed: -Admission date of 9/14/21 -Diagnoses of Oppositional Defiant Disorder and Post Traumatic Stress Disorder -Current treatment plan dated 10/11/21 does not include any specifications regarding phone call parameters Review on 11/23/21 of Client #3's record revealed: -Admission date of 9/29/21 -Diagnoses of Major Depressive Disorder-Recurrent, Attention Deficit Hyperactivity Disorder-Combined type and Sibling relational problem -Current treatment plan dated 10/11/21 does not include any specifications regarding phone call parameters Interview on 11/23/21 with Client #1'revealed: Interview on 11/23/21 with Client #1 revealed:			MHL047-	158	B. WING			-	
CANYON HILLS TREATMENT FACILITY RAEFORD, NC 28376	NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CAU ID PRETIX CAUTHOR CAUT	CANYON	N HILLS TREATMENT	FACILITY						
Review on 11/23/21 of Client #1's record revealed: -Admission date of 9/22/21 -Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder-combined presentation and Unspecified Trauma and Stressor Related Disorder -Current treatment plan dated 10/11/21 does not include any specifications regarding phone call parameters Review on 11/23/21 of Client #2's record revealed: -Admission date of 9/14/21 -Diagnoses of Oppositional Defiant Disorder and Post Traumatic Stress Disorder -Current treatment plan dated 10/11/21 does not include any specifications regarding phone call parameters Review on 11/23/21 of Client #3's record revealed: -Admission date of 9/29/21 -Diagnoses of Major Depressive Disorder-Recurrent, Attention Deficit Hyperactivity Disorder-combined type and Sibling relational problem -Current treatment plan dated 10/11/21 does not include any specifications regarding phone call parameters Interview on 11/23/21 with Client #1 revealed:	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECE	CIENCIES DED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE	
calls -He was allowed to use the telephone during the scheduled times -He disliked that staff would remain present during the phone call while on speaker phone Interview on 11/23/21 with Client #2 revealed:	V 364	Review on 11/23/21 revealed: -Admission date of -Diagnoses of Disru Disorder, Attention combined presental and Stressor Relate -Current treatment include any specific parameters Review on 11/23/21 revealed: -Admission date of -Diagnoses of Oppo Post Traumatic Stre-Current treatment include any specific parameters Review on 11/23/21 revealed: -Admission date of -Diagnoses of Major Recurrent, Attention Disorder-combined problem -Current treatment include any specific parameters Interview on 11/23/21-He did not have proalls -He was allowed to scheduled times -He disliked that staduring the phone calls -He mission date of scheduled times -He disliked that staduring the phone calls -He phone cal	9/22/21 uptive Mood Dy Deficit Hyperation and Unspeed Disorder plan dated 10/cations regarding of Client #2's 9/14/21 positional Defiar ess Disorder plan dated 10/cations regarding of Client #3's 9/29/21 pr Depressive End Deficit Hyperatype and Sibling plan dated 10/cations regarding p	vsregulation ctivity Disorder-ecified Trauma 11/21 does not ng phone call record 11/21 does not ng phone call record 11/21 does not ng phone call record 11/21 does not ng phone call 11/21 do	V 364				

6899

Division of Health Service Regulation STATE FORM

2HS811 If continuation sheet 6 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL047-158	B. WING 1			C 11/24/2021	
	PROVIDER OR SUPPLIER N HILLS TREATMENT	FACILITY 769 ABE	DDRESS, CITY, S RDEEN ROAI D, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 364	-He could not have telephone -He was allowed to the scheduled times -He would have to hand staff stayed in to the staff stayed in the staff dialed the speaker -He would like to haw with his family Interview on 11/24/2 #2 revealed: -Client and guardian present during phore -This information is guardians during the staff supervising the number to ensure of approved person or interview on 11/24/2 revealed: -The telephone polithe agency -Guardians of client have no contact with	privacy when using the make telephone calls during s have the phone on speaker the room during the phone call 21 with Client #3 revealed: ere monitored by staff enumber and put the call on ave privacy when speaking 21 with Qualified Professional has are aware that staff are he calls and call is on speaker shared with clients and e admission process he call do dial the phone dient is speaking with	V 364				

6899

Division of Health Service Regulation STATE FORM