

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL045-127</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>EQUINOX RTC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>41 HERO'S WAY HENDERSONVILLE, NC 28792</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>A compliant survey was completed on 4/1/22. The complaint (# NC186997) was unsubstantiated. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents</p> <p>This facility is licensed for 37 and currently has a census of 9. The survey sample consisted of an audit of 1 current client.</p>	V 000		
V 109	<p><b>27G .0203 Privileging/Training Professionals</b></p> <p>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS</p> <p>(a) There shall be no privileging requirements for qualified professionals or associate professionals.</p> <p>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(d) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> <li>(1) technical knowledge;</li> <li>(2) cultural awareness;</li> <li>(3) analytical skills;</li> <li>(4) decision-making;</li> <li>(5) interpersonal skills;</li> <li>(6) communication skills; and</li> <li>(7) clinical skills.</li> </ol> <p>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for</p>	V 109		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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V 109	<p>Continued From page 1</p> <p>MH/DD/SAS.</p> <p>(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.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 Qualified Professionals (Residential Supervisor) (RS/QP) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:</p> <p>Record review on 3/29/22 for Client #1 revealed: -Date of Admission-4/1/21 -Age: 18 years -Diagnoses- Major Depressive Disorder, General Anxiety Disorder, Post Traumatic Stress Disorder, Cannabis Use Disorder.</p> <p>Record review on 3/29/22 for the Residential Supervisor/QP (RS/QP) revealed: -Date of Hire- 6/6/19 as a QP. -Job description for Team Manager signed 7/22/21 included but not limited to job duty of "oversees the residential programmatic, schedule, training and supervision of Mentor and Lead Mentor staff."</p> <p>Record review on 3/29/22 for Former Staff (FS)</p>	V 109		

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V 109	<p>Continued From page 2</p> <p>#1 revealed:                      -Date of hire- 11/26/18 as mentor.                      -Date of termination: 2/26/22.                      -Supervision Plan/contract dated 8/4/21 signed by FS #1 and the RS/QP revealed:                      -Classification- shift coordinator                      -Supervision Frequency- at least monthly                      -Supervision Duration- at least 1 hour                      -Goals-(1) maintaining proper ration and provide opportunities for regulation and (2) advocate for self when overwhelmed.                      -There was no documentation of monthly supervision.</p> <p>Record review on 3/29/22 of complaint report dated 3/10/22 revealed:                      -"[Client #1] has been at Equinox Residential Facility since April 1, 2021 ...reported [Client #1] started having a relationship with an Equinox Staff member [FS#1] in October 2021 ...started writing poetry back and forth then in January 2022 they were sending nude photos to each other via Snapchat ...late January 2022 and early February 2022 [Client #1] and [FS #1] held hands, kissed each other and touched each other's breasts, penis and vagina underneath their clothes ....happened multiple times and that it was consensual ...there was not any penetration ...[FS #1] is no longer employed as she quit 9 days ago ...not aware of any other residents being involved with [FS #1]"</p> <p>Interview on 3/9/22 with FS #1 revealed:                      -Worked at Equinox 3 years. Began as a mentor then shift coordinator responsible for scheduling and day to day support for kids. Communicated to team managers if there was something they needed to know.                      -Was Client #1's guide beginning of 2022.                      Guides helped students through their phase work</p>	V 109		

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V 109	<p>Continued From page 3</p> <p>and daily struggles.</p> <p>-"No I did not give [Client #1] my phone number."</p> <p>-"No I did no texting from my phone or staff phone."</p> <p>-"No we had no social media contact."</p> <p>-"No [Client #1] never requested my number."</p> <p>-She did receive feedback from other mentors that Client #1 was exhibiting some co-dependent behaviors when she was not there and she addressed it with Client #1 and he said ok.</p> <p>-2 other kids made up stuff to get back at Client #1. "Everyone was interviewed and nothing found."</p> <p>-She was not aware of allegations Client #1 had made, only the allegations from the 2 boys.</p> <p>-She met with the Program Director (PD) and the Human Resources (HR) Director. She made the decision herself to move to overnight when allegation with Client #1 was brought up.</p> <p>-"[Program Director] first told me what the kids were saying. He asked me about it and there was nothing. I was told that they would speak to [Client #1] about it. I got a call from the PD a week later saying, 'yea we figured it out; it was just retaliation with the boys'."</p> <p>-She didn't remember when she started over-night shift.</p> <p>-Her supervisor was the RS/QP. They talked about whole situation and how it affected her but she received no additional supervision.</p> <p>-"I was left in the dark about the whole thing. I got no information; no sense of closure. I was pretty crushed. I went to overnight and was never given any information."</p> <p>-All staff were sent boundaries and social media policy. "Yes I signed it."</p> <p>-"I never talked to [Client #1] during his home visits. No texts or social media contacts."</p> <p>Interview on 3/30/22 with Staff #2 revealed:</p>	V 109		

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V 109	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>-Been at facility a year and half. She has been a guide with former students and was currently a guide. A guide is the primary staff who student goes to if they need extra support; the guide makes up and gives assignments like hero's principals to help phase up. Gave example of honesty and respectfulness assignments.</li> <li>-Guides spend a little bit of extra time with guidelets but not hours. If in the common room, a guide might say hey, want to work on guide assignments. "Yes, definitely, I would you be concerned about guide spending a lot of time with guidelet."</li> <li>-She had approached FS #1; "hey, it makes [Client #1] uncomfortable." Sometimes they would go to kitchen to make dinner, maybe on Sunday, warm up pizza and they were gone for 2 hours.</li> <li>-Staff #2 "told my superior" (RS/QP). She wasn't sure what happened with RS/QP talking to FS #1.</li> <li>-They would type messages on her personal phone and pass back and forth. It was FS #1's personal phone because FS #1 said there was student who wanted to listen in so that's why they (she and Client #1) communicated this way.</li> <li>-Lead Residential Counselor/ Shift coordinator always has the house phone with them, it's an iphone.</li> <li>-She observed FS #1 and Client #1 pass FS #1's personal phone. They were in the art room, now called the laundry room. The whole milieu was in there at the time.</li> <li>-When asked as a guide would it be ok to give a client their phone, she replied, "NO, definitely not, there was a strict policy about not communicating via social media"</li> <li>-On 1/4/22 during an outing with Client #1 and another student she asked Client #1 how this started and he said FS #1 airdropped him her phone/email and said send funny memes. He also stated FS #1 was a support system when he</li> </ul>	V 109		

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V 109	<p>Continued From page 5</p> <p>was on LOAs (Leave of Absence).</p> <p>-She told the RS/QP mid to late November that FS #1 and Client #1 were sending messages on her phone app and spending so much time together. The RS/QP suggested she talk with FS #1. After giving FS #1 feedback, she stopped passing her phone back and forth but was still spending a lot of time with Client #1.</p> <p>-FS #1 gave Client #1 special treatment, letting Client #1 get away with more than other clients. She was very firm with boundaries with other students but not Client #1.</p> <p>-What happened with FS #1 and Client #1 was common knowledge. The most recent thing was allegation that Client #1 and FS #1 had sex. Client #1 made sarcastic comment and Client #2 responded and said "at least I didn't have sex with [FS #1]". She checked in with Client #1 about it and he seemed not concerned.</p> <p>-"Anything weird that happened (between [Client #1] and [FS #1]) happened on campus." They did not go on outings alone.</p> <p>Interview on 3/30/22 with Staff #3 revealed:</p> <p>-Had been here one year, started last June.</p> <p>-She was a guide now, got guide trained about 1.5 months ago.</p> <p>-Training for guide included review of policy/procedure, sat down with my supervisor (RS/QP) and went over it, talked through it. She doesn't have a guidelet yet; hasn't been assigned one. Therapist assigns guides or clients request.</p> <p>-She had worked with FS #1 and had no concerns in general, but when a fellow student made a joke about it (having a relationship with Client #1), staff talked to Client #1 about it. That is when staff noticed that FS #1 and Client #1 spent a lot of time together. She didn't remember when this happened but was before a former student left the end of January. Client #2 wrote</p>	V 109		

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V 109	<p>Continued From page 6</p> <p>Client #1 slept with FS #1 on board in the house. FS #1 wasn't there when that happened, not sure it did happen but Client #2 may have made an inappropriate comment.</p> <p>-She heard about the relationship from someone else. One of the kids told another staff (about the inappropriate relationship) and she heard about it from another staff. There were a few staff that had heard it so she isn't sure who heard it first.</p> <p>-They (Client #1 and FS #1) spent time together as guide/guidelet going over assignments. It wasn't different in an extremely different way so she didn't see it as alarming. She then told another staff that she noticed they were spending a lot of time together. She could notice it because she wasn't one of the guides. Her shift was 3:45pm-10:00pm. Kids were in bed by 9:00pm.</p> <p>-Staff would sit outside the rooms, if the student needed a little extra support or if they needed someone to talk to to wind down, would stand at door.</p> <p>-If a kid was "on arms", staff sit inside the room during day shift but night shift would move couch so they can see room. Staff do not sit in their room. All the rooms open to the common room, can all see each other.</p> <p>-A few other staff talked to the RS/QP. She never witnessed inappropriate behavior but noticed any time another student or Client #1 mentioned FS #1, it went in their shift note. This started this after they heard about inappropriate relationship.</p> <p>-After reports were made, FS #1 got moved to overnight.</p> <p>-"[FS #1] never talked to me about Client #1. The only thing I heard from Client #1 was after he got back from LOA in February, he said he was thinking about things with FS #1 but when I asked him about it he shut down." She put it in his shift</p>	V 109		

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V 109	<p>Continued From page 7</p> <p>note.</p> <p>Interview on 3/30/22 with the RS/QP revealed:</p> <ul style="list-style-type: none"> <li>-He supervised FS #1. Had been working here almost 3 years.</li> <li>-He heard of the allegations but not told of them by Client #1.</li> <li>-In 3 years, he hasn't had this before. He has been a supervisor about one year. One former employee/former student had inappropriate communication. That staff was PRN (as needed) and she left.</li> <li>-This was first time, there were allegations.</li> <li>-He was not part of that meeting with FS #1, doesn't know why that decision was made to move FS #1 to overnight.</li> <li>-No supervision issues with FS #1, she was working here when he started; doesn't think he she had any disciplinary actions.</li> <li>-He was her supervisor for a year. He didn't observe anything but feedback he got from other coworkers was that she was spending more time with Client #1, like check ins, taking time away from milieu. She had been given feedback from her peers' about this extra time with Client #1.</li> <li>-FS #1 was invested in her guidelets, assigning outside homework. She was enmeshed in a good way; found time for them; not just Client #1.</li> <li>-"Client #1 was her only guidelet", he thinks.</li> </ul> <p>When Client #1 got here in April, client's give their top 3 choices for guides; staff make a decision about who would be best fit. Not a lot of staff turnover in past year but yes turnover prior to this past year.</p> <ul style="list-style-type: none"> <li>-Clients are assigned a guide after 90 days; then the staff get training. He had a power point of what a guide does but no policy. They can lean on supervisor for information as well.</li> <li>-Clients get a guide on threshold phase (3rd phase). Guides are not an extension of therapist;</li> </ul>	V 109		



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V 109	<p>Continued From page 8</p> <p>guides are a specified mentor they can go to; if client had specific issue, at the time, check in when needed.</p> <p>-Before he was supervisor, he was FS #1's coworker. She was a guide with others. She was a lead counselor</p> <p>-Lead counselor is someone who has been here, knows boundaries, shows skills, uses white board, schedule meetings, texts to communicate about clients; have shift change meeting about kids behaviors, anything need to know; encourage staff to communicate outside of meetings.</p> <p>-Had all staff meeting recently. It was the first one they had one in awhile.</p> <p>-Have smaller staff meeting per shift.</p> <p>-Staff #2 told him about FS #1 spending a lot of time with Client #1. He doesn't remember when Staff #2 told him but it was in person. Staff #2 told him "along the lines FS #1's check ins with Client #1 are long, leaves us in dorm to do the work, didn't want it to look suspicious. He asked Staff #2 if she had given FS #1 peer to peer feedback. Staff #2 said yes, and he said let me know if there are other concerns. He didn't say anything to FS #1 at that point because it wasn't unusual in his history of working with her for her spending time with her guidelets.</p> <p>-He read shift notes, am and pm notes but did not have any cause for concerns when reviewing the shift notes.</p> <p>-He did not have 1 to 1 conversation with FS #1 about boundaries. They did a training on boundaries with test attached in staff meetings.</p> <p>-Staff #2 was the only one he recalls that told him about interactions with FS #1 and Client #1.</p> <p>-He was aware FS #1 had supervision contract to get monthly supervision. He had not met with his supervisor when he was a mentor and he didn't know until couple of months ago that he was</p>	V 109		

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V 109	<p>Continued From page 9</p> <p>supposed to meet with his supervisee. It was difficult to find time to meet with her 1:1 because she went to overnights. He would see her real quick and check in and it wasn't formal. There was no documentation of the meetings.</p> <p>-He didn't recall Staff #2 saying there was electronic communication between Client #1 and FS #1.</p> <p>Interview on 3/31/22 with the PD revealed:</p> <p>-Had meeting with FS #1, because one of their former clients stated that Client #1 was communicating with this young lady. He met with FS #1, told her what was alleged. FS #1 intends to be a human service professional. He encouraged her to tell him what was going on to protect Client #1 and her because of possible consequences. He broached allegations with her. She said she only used cottage phone to talk with him about sensitive things that he didn't want cottage mates to hear.</p> <p>-He met with Client #1 and asked if any staff had done anything "lascivious, deleterious, lewd". Client #1 said no issues. He said FS #1 was supportive to him.</p> <p>-FC #5 reported it initially when he and Client #1 had a falling out. FC #5 broke contract on LOA 11/24/21-11/29/21 and had level drop. This is when he reported communication between Client #1 and FS #1. They took FC #5's accusation seriously, interviewed people, had documentation signed, went into detail about could happen to staff; staff responded well. They had treatment team meeting, brought in Client #1 asked about any staff contact which he vehemently denied. Brought in FS #1 who also denied but was demoted to overnight shift. No longer a lead and no longer a guide due to being overnight.</p> <p>-FS #1 signed the email reviewing boundary and social media policy. Also had individual/group</p>	V 109		

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V 109	<p>Continued From page 10</p> <p>meetings with all staff and had staff sign.</p> <p>-Client #1 came back from home visit in February and tested positive for nicotine. Treatment team met, because he violated LOA contract, he was dropped a couple levels; "this is when he (Client #1) did 360 and said he and FS #1 had engaged in deleterious behavior".</p> <p>-From my perspective there was no evidence of deleterious action; no proof. Both allegations came after LOAs and clients had level drops. Both were anger reactions.</p> <p>-PD worked with FS #1 on her last shift. Client #1 was seeking FS #1 out; PD told FS #1 to avoid Client #1 and stay away from him. Client #1 said to PD on 2/26/22 he was angry and told him he could press charges against somebody but wouldn't say who. Client #1 had 2 separate opportunities to give PD name, date, any info about any allegations.</p> <p>-FS #1 had not been his guide for 2 months.</p> <p>-Client #1 was dropping hints to other boys about interaction with FS #1. This happened after FS #1's last day which was 2/26/22.</p> <p>-Staff #2 and Staff #3 mentioned to therapist what Client #2 had written on the board on that weekend. They said to other staff that Client #1 had made comments about FS #1.</p> <p>-No other consumer made comments to him about Client #1 and FS #1 and clients will bring him everything under the sun. Client #1 had weeks to make report. He never got proof.</p> <p>-He takes any allegation to the clinical director.</p> <p>Interview on 3/29/22 with Executive Director/Clinical Director revealed:</p> <p>-They self-reported to CPS and did their own internal investigation. Parents were informed. The PD provided retraining for all staff on Boundaries and Social Media Use and Inservice training on Client Supervision Expectations.</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL045-127</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>EQUINOX RTC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>41 HERO'S WAY HENDERSONVILLE, NC 28792</b>
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V 109	Continued From page 11  Additional in-service trainings included Abuse Reporting Policy, NCDHSR (North Carolina Division of Health Service Regulation) Definitions: Duty to Report, Authority to Intervene and Caretaker Definition. -FS #1 no longer worked there. She was demoted and then left on her own accord. No other similar or other allegations.	V 109		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection  G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort	V 132		

Division of Health Service Regulation

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V 132	<p>Continued From page 12</p> <p>to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure allegations of abuse were reported to the North Carolina Health Care Personnel Registry (HCPR) of the Division of Health Service Regulation within five working days. The findings are:</p> <p>Review on 3/29/22 of Client #1's record revealed: -Date of Admission- 4/1/22 -Age- 18 years -Diagnoses- Major Depressive Disorder, General Anxiety Disorder, Post Traumatic Stress Disorder, Cannabis Use Disorder.</p> <p>Record review on 3/29/22 for Former Staff (FS) #1 revealed: -Date of hire- 11/26/18 as mentor. -Date of termination: 2/26/22.</p> <p>Record review on 3/29/22 of complaint report</p>	V 132		

Division of Health Service Regulation

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V 132	<p>Continued From page 13</p> <p>dated 3/10/22 revealed:                      -"[Client #1] has been at Equinox Residential Facility since April 1, 2021 ...reported [Client #1] started having a relationship with an Equinox Staff member [FS#1] in October 2021 ...started writing poetry back and forth then in January 2022 they were sending nude photos to each other via Snapchat ...late January 2022 and early February 2022 [Client #1] and [FS #1] held hands, kissed each other and touched each other's breasts, penis and vagina underneath their clothes ....happened multiple times and that it was consensual ...there was not any penetration ...[FS #1] is no longer employed as she quit 9 days ago ...not aware of any other residents being involved with [FS #1]"</p> <p>Review on 3/22/22 of IRIS (Incident Reporting Improvement System) revealed:                      -No report was submitted by facility for Level III incident.                      -No report was made to HCPR regarding allegation of sexual abuse by staff.</p> <p>Interview on 3/29/22 with Executive Director/Clinical Director revealed:                      -They self-reported to CPS and did their own internal investigation. Parents were informed. The PD provided retraining for all staff on Boundaries and Social Media Use and Inservice training on Client Supervision Expectations. Additional in-service trainings included Abuse Reporting Policy, NCDHSR (North Carolina Division of Health Service Regulation) Definitions: Duty to Report, Authority to Intervene and Caretaker Definition.                      -FS #1 no longer worked there. She was demoted and then left on her own accord. No other similar or other allegations.                      -Was not aware they also needed to make an</p>	V 132		

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V 132	Continued From page 14 allegation report to HCPR.	V 132		