Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-158	A. BUILDING: ______ B. WING ______	C 04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS TREATMENT FACILITY	769 ABERDEEN ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on April 29, 2022. The following complaints were substantiated (Intake #NC00187681, #NC00188197, #NC00188151, #NC00188014 and #NC00187926). These complaints were unsubstantiated (Intake #NC00187652 and #NC00187735). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility for Children and Adolescents. This facility is licensed for 24 beds and currently has a census of 21. The survey sample consisted of 6 current clients and 1 former client.	V 000	DHSR - Mental Health MAY 27 2022 Lic. & Cert. Section	
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive	V 314	Canyon Hills Treatment facility will provide a structured living environment for children who require supervision and specialized interventions on a 24hour basis. Each child will be given a specific revised plan based on their treatment needs and each staff assigned will be trained on the behavior plan and supervision requirements immediately.	05/24/2022

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 05/24/2022

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community setting.
(e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment.
(f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area.
(g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide a structured living environment for children who required supervision and specialized interventions on a 24-hour basis. This affected 4 of 6 audited clients (client #4, client #5, client #6 and client #7). The findings are:

Review on 4/29/22 of client #4's record revealed:
-A 15 year old male.
Admission date of 12/6/21.
-Diagnoses: Conduct Disorder, Attention Deficit

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V 314	Continued From page 2 Hyperactivity Disorder- by history and Post Traumatic Stress Disorder. -Treatment plan updated 4/20/22 listed history of defiance, mood instability, apathy and four attempts to elope within 45 days during community placement. Review on 4/29/22 of client #5's record revealed: -A 16 year old male. -Admission date of 6/2/21. -Diagnoses: Depressive Mood Dysregulation Disorder, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. -Treatment plan updated 4/13/22 listed history of numerous placements and at the age of 14 stealing his grandmother's van and attempting to drive to Concord. Review on 4/29/22 of client #6's record revealed: -A 17 year old male. -Admission date of 2/7/22. -Diagnoses: Conduct Disorder, Attention Deficit Hyperactivity Disorder and Unspecified Trauma and Stress related Disorder. -Treatment plan updated 4/20/22 listed history of elopements. While at another treatment program with peer broke into a winery, drank and stole a vehicle from a junkyard to drive a peer to their home 3.5 hours away. He is currently faced with charges of possession of a stolen vehicle. While at a hospital, he eloped and remained gone for approximately six weeks. Review on 4/29/22 of client #7's record revealed: -A 17 year old male. -Admission date of 12/3/20. -Diagnoses: Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder and Unspecified Trauma Stressor Related Disorder.	V 314		

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-Treatment plan updated 3/9/22 listed history of struggling at school, in the community and foster home due to physical and verbally aggressive behaviors with concerns of being a flight risk.

Interview on 4/29/22 with client #4 revealed:
-He and the other client had plotted to leave the facility that day.
-He went out the front door and the other clients went out the back door.
-There was no staff at either door as they were somewhere else on the unit.
-He was just in the woods area not far from the facility and decided to come back on his own.
-He was gone from the facility for about 30 minutes.

Interview on 4/29/22 with client #5 revealed:
-There were only three staff working with two on the unit and the other doing phone calls.
-He stated "the female on the fire door was small, so we figured we could overtake her if needed."
-"The staff went to see about another client and left the fire door, so I went out the door."
-"I was walking down the road and planning to hitchhike to my friends house".
-"I was gone for about 30 minutes and picked up by a staff."

Interview on 4/29/22 with staff #2 revealed:
-There were four clients that eloped but client #4 and client #5 were returned within 30 minutes.
-The other two, client #6 and client #7 have not returned.
-The local police department, sheriff department and guardians were notified.
-Three staff were working the day of the incident.
-One staff completed their shift and resigned at the end of her shift.
-The facility doors are not locked but staff are

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V 314	Continued From page 4 positioned at doors. -The doors are locked from the outside but not the inside. -The clients are aware of the doors being unlocked from the inside. Interview on 4/29/22 with staff #7 revealed: -He confirmed he was one of three staff on shift. -He decided to take one client outside to recreation area to deescalate issue with a client on the unit. -Other clients grabbed their shoes to join them. -He saw Client #4 run out back door and requested all clients to return inside. -Client #4 refused to come in but finally complied and entered the building. -He and fellow staff completed room checks to ensure all clients were back in the building. -During the bedroom checks, staff discovered client #6 and client #7 were gone. -Staff contacted the police. -He left common area to assist fellow staff. -Was also informed that Client #4 and Client #5 left from another door. -He remained on the unit to maintain supervision and safety with other clients on unit. -Staff from the other unit left to look for clients that had eloped. -He was told by other clients on the unit this event was planned by clients to happen. -He stated the agency protocol for taking clients to recreation area was to have all staff on shift outside with clients. -He stated that agency protocol for elopement is to notify management and receive further directives. Interview on 4/29/22 with staff #8 revealed: -She didn't know the specifics as she was not on the unit.	V 314		

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-She was assisting clients with making phone calls.
-She was upfront in the game room.
-Before she left the unit, staff were in place and clients were calm.
-The door to the room where the phone calls were made was closed to give the clients privacy.
-She heard a commotion and came back to the unit and was informed client #4, client #5, client #6 and client #7 had eloped
-She was trained with runaway to contact nurse on duty and the Facility Manager.

Interview on 4/29/22 with the Qualified Professional revealed:
-She did not work on the date of the incident.
-She was told the four clients quickly rushed up on staff and went out the fire door.
-The fire door is unlocked for emergency use.
-Staff would sit or stand by the fire door to supervise clients.

Interview on 4/29/22 with Clinical Director revealed:
-She was informed about the incident the next day.
-She was informed "the four clients bombarded the staff member and went out the fire door."
-She was not informed of the staff member who was at the fire door.
-This was her first time of clients running and not found or returning.
-The facility has never had clients elope for more than one hour.
-The agency will hold the bed for the 2 other clients for 15 days.
-The guardians and local police were notified of the runaway for each client.
-"The agency staff client ratio was one staff per three clients."

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V 314	Continued From page 6 Review on 4/29/22 of the facility's investigation summary dated for 4/23/22 revealed: -Incident occurred on 4/23/22. -Incident reported on 4/23/22 by Staff #7 to Nurse #1. -Incident investigated by the Program Director. -"Summary of the investigation findings: [Client #4], [Client #5], [Client #6] and [Client #7] planned they would elope from the facility around dinner. [Client #6] and [Client #4] complained of stomach aches and requested to return to their rooms. [Client #6] went to [Client #4's] room a couple of times and was directed to return to his own room. [Staff #7] decided to take [Client #4], [Client #5], [Client #6], [Client #7] outside to play basketball while staff monitored the consumers that were on the inside. [Staff #8] was in the recreational room assisting consumer with phone calls. [Staff #6] and another client came back inside and walked down to [Client #7] doorway and conversing back and forth until they were directed by staff to return to the common area. [Client #6] and [Client #4] did not comply and went into their rooms. While staff was turned addressing another consumer, [Client #4] ran from his room and out of the fire exit door. Staff immediately followed [Client #4] and found him standing on top of their air conditioning unit. Staff directed to get down, but [Client #4] refused. Staff requested assistance. [Client #4] ran out the front door and the other consumers eloped. [Nurse #1] who was on the other unit and another staff went in pursuit of [Client #4]. Staff made phone call to 911. Another consumer attempted to take the phone from staff to prevent her from making call to law enforcement. [Staff #7] stepped in to assist staff with another consumer. Two of the consumers, [Client #5] and [Client #4] were located by staff and law enforcement and returned back to the	V 314		

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facility."

Review on 5/2/22 of the facility's Plan of Protection dated 5/2/22 submitted by the Quality Assurance Director revealed the following:
-"What will you immediately do to correct the above rule violations in order to ensure supervision? Canyon Hills Treatment Facility will continue to monitor the clients while in the facility and ensure each client is supervised by team members as they move about the facility.
-Describe your plans to make sure the above happens. Canyon Hills Treatment Facility will implement the following standards regarding emergency provisions of total isolation: 1.) Team members will be assigned at the beginning of each shift to a client by the Shift Lead, 2.) Team members will be trained on positioning and communications by Shift Lead immediately and 3.) All Shift Leads will be retrained on protocols including checking door alarms at the beginning of each shift and randomly throughout the day."

Client's #4-7 with an age ranges from 15 to 17 years old with diagnoses including Attention Deficit Hyperactivity Disorder, Conduct Disorder, Depressive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Post Traumatic Stress Disorder and Unspecified Trauma and Stress Related Disorder. The client's histories included verbal aggression, physical aggression and elopement. On 4/23/22 Client's #4-7 eloped from the facility.
During the time of the elopement the supervision of the clients in the facility went below the required staff to client ratio, leaving the facility's exit doors unsupervised, which allowed the four clients to exit and elope from the facility. Two of the four clients (client #4 and client #5) returned to the facility within 30 minutes. Client #6 and

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V 314	Continued From page 8 Client #7 were still missing from the facility upon exit of this survey. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 314	Client #7 returned to facility on 04/30/2022	05/24/2022
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 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	V 364	Canyon Hills will ensure the clients rights are observed in the 24hour facility. Based on the individual treatment plans, guardian consent, or phone parameters, each client will be afforded time to make and receive phone calls that are confidential. Staffwill be retrained on the procedures for ensuring the phone calls are documented,how and when they can occur and who is responsible for initiating phone calls.	05/24/2022

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V 364	Continued From page 9 calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money;	V 364		

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V 364	Continued From page 10 (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10) Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's 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	V 364		

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V 364	Continued From page 11 restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the	V 364		

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V 364	Continued From page 12 formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that clients can make and receive confidential telephone calls affecting 3 of 7 audited clients, 2 current clients (Client #2 and Client #3) and 1 former client (Former Client #1).	V 364		

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The findings are:

Review on 4/13/22 of Former Client #1's record revealed:
-Admission date of 1/4/22.
-Diagnoses of Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder- Combined presentation.
-The current treatment plan dated 3/21/22 does not include any specifications regarding phone call parameters.

Review on 4/13/22 of Client #2's record revealed:
-Admission date of 4/22/21.
-Diagnoses of Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder.
- The current treatment plan dated 3/29/22 does not include any specifications regarding phone call parameters.

Review on 4/29/22 of Client #3's record revealed:
-Admission date of 3/7/22.
-Diagnoses of Oppositional Defiance Disorder, Post-Traumatic Stress Disorder and Attention Hyperactivity Deficit Disorder.
- The current treatment plan dated 4/13/22 does not include any specifications regarding phone call parameters.

Interview on 4/27/22 with Former Client #1 revealed:
-Staff is in the room when on phone.
-Don't have privacy and felt staff would listen to phone calls.
-None of his calls were on speaker phone.

Interview on 4/14/22 with Client #2 revealed:
-During phone call, staff dialed the number.
-Staff remained in the room during the call.
-He did not remember if his calls were placed on

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V 364	Continued From page 14 the speaker phone. Interview on 4/29/22 with Client #3 revealed: -Staff would dial the number and pass the phone. -Staff did remain in the room while on the call. -He would prefer to have a cell phone so he could text. Interview on 4/29/22 with Staff #8 revealed: -When clients make phone calls, staff make the call and placed on speaker phone. -We as staff have to remain in the room during the phone call. -The door is closed for privacy from others hearing the call. Interview on 4/28/22 with the Clinical Director revealed: -Phone calls occurred in the game room or nursing station. -Staff supervised calls outside the door as to monitor the breaking of phone and other property in the room. -Nursing station had list for each client identifying which calls were to be placed on speaker phone. -Calls placed on speaker phone were per the request of the legal guardian.	V 364		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within	V 367	All level II incidents will be reported to IRIS by the Registered Nurses on staff within the 72 hours of notification. Clinical Director and QA will monitor occurrences and reporting requirements weekly to ensure compliance with statute.	05/24/2022

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90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:

(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.

(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:

(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.

(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:

(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.

(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and

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V 367	Continued From page 16 Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by:	V 367		

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V 367	Continued From page 17 Based on record review and interviews, the facility failed to ensure a Level II incident report was completed and submitted to the Local Managed Entity/Managed Care Organization (LME/MCO) within 72 hours. The findings are: Review on 4/13/22 of Former Client #1's record revealed: -Admission date of 1/4/22. -Diagnoses of Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder- Combined presentation. Review on 4/13/22 of Client #2's record revealed: -Admission date of 4/22/21 -Diagnoses of Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder Review on 4/13/22 of the Facility's internal incident report revealed: Incident on Former Client (FC) #1: -"Nurse was called to the floor because it was report by [Staff #1] that consumer was aggressive and had kicked [Staff #1]. When the nurse arrived to Unit B the consumer was refusing to go to his room to reset. The consumer was escorted to his room by [Former Staff #10] and [Staff #1] where he began to kick the wall. The consumer refused to be processed by [Former Staff #10] and [Staff #1] or to reset. The consumer behavior escalated, he began to throw his belongings around his room banging on the wall in his closet, kicking his shelves, banging on his window. The consumer began to bang his head into the window. [Staff #5] tried verbally to redirect the consumer from his self-injurious behavior the consumer threw a clothes basket at [Staff #5] and [Former Staff #10]. The nurse directed for all loose objects and clothing to be removed to	V 367		

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provide safety for the staff. During this process the consumer ran at [Staff #5] and [Former Staff #10] punching [Former Staff #10]. [Former Staff #10] pushed consumer back into the room. The Consumer was warned that he would be put in a hold which decreased the consumer back into the room. The consumer was warned that he would be put in a hold which decreased the consumers aggression.The [Clinical Director] placed the consumer on suicide precautions at 3:34pm for self-injurious behavior..."

Incident regarding on Client #2:
-Review of facility records on 4/13/22 revealed their was no level I (Internal) incident report completed.

Internal investigation completed on 4/8/22 revealed the following:
-Consumer's current was admitted to facility on 04/02/2021.
-Consumer made allegation toward [Former Staff #11] on 04/01/2022 to Facility Manager.
-Consumer wrote statement regarding incident on 04/01/2022.
-The Residential Advisor staff accused [Former Staff #11] was interviewed and statement written taken on 04/01/2022. [Former Staff #10] was removed from shift immediately once client made allegation to managers on 04/01/2022.
-Staff has been employed with the facility since 2016.
-Consumer never asked to see nurse for injury on that date as reported by the nurses.
-Staff was with consumer during time documented and consumer was in banter about chips and snacks. Consumer playfully reached for the snack and was told if he reached in her bag again, she would "get him". It was April Fool's Day and consumer stated he wanted to

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V 367	Continued From page 19 prank her ([Former Staff #11]) and reported later after being teased by the other consumers the she "slapped" him. -The findings of the report stated staff failed to implement professional conduct at all times while interacting with consumers. Review on 4/12/22 of the facility incident reports in the Incident Report Improvement System (IRIS) revealed none of the above incidents were recorded or submitted by the agency. During interview on 4/13/22 the Clinical Director reported: -She was unsure if an incident report was completed on Former Client #1 situation. -The incident report was not completed in a timely manner on Client #2.	V 367		
V 514	27E .0102 Client Rights - Prohibited Procedures 10A NCAC 27E .0102 PROHIBITED PROCEDURES In each facility the following types of procedures shall be prohibited: (1) those interventions which have been prohibited by statute or rule which shall include: (a) any intervention which would be considered corporal punishment under G.S. 122C-59; (b) the contingent use of painful body contact; (c) substances administered to induce painful bodily reactions, exclusive of Antabuse; (d) electric shock (excluding medically administered electroconvulsive therapy); (e) insulin shock; (f) unpleasant tasting foodstuffs; (g) contingent application of any noxious	V 514	All staff will be trained on Alternatives to Restrictive Interventions that include updates to previous training on EBPI. Each staff member will also be trained on deescalation techniques as well as prohibited procedures to decrease the intensity of behaviors. The Clinical Director and/or QA Dir will ensure compliance with statute by monitoring and debriefing with staff after each incident that occurs that requires physical intervention.	05/24/2022

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substances which include but are not limited to noise, bad smells or splashing with water; and
(h) any potentially physically painful procedure, excluding prescribed injections, or stimulus which is administered to the client for the purpose of reducing the frequency or intensity of a behavior.
(2) those interventions determined by the governing body to be unacceptable for or prohibited from use in the facility.

This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to adhere to prohibited procedures administered to the client or the purpose of reducing the frequency or intensity of a behavior, affecting 1 of client (Former Staff #1). The findings are:

Review on 4/13/22 of Former Client #1's record revealed:
-Admission date of 1/4/22.
-Diagnoses of Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder- Combined presentation.

Review on 4/13/22 of the Facility's internal incident reports revealed:
Incident on Former Client (FC) #1:
-"Nurse was called to the floor because it was report by [Staff #1] that consumer was aggressive and had kicked [Staff #1]. When the nurse arrived to Unit B the consumer was refusing to go to his room to reset. The consumer was escorted to his room by [Former Staff #10] and [Staff #1] where he began to kick the wall. The consumer refused to be processed by [Former Staff #10] and [Staff #1] or to reset. The consumer behavior escalated, he began to throw his belongings

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around his room banging on the wall in his closet, kicking his shelves, banging on his window. The consumer began to bang his head into the window. [Staff #5] tried verbally to redirect the consumer from his self-injurious behavior the consumer threw a clothes basket at [Staff #5] and [Former Staff #10]. The nurse directed for all loose objects and clothing to be removed to provide safety for the staff. During this process the consumer ran at [Staff #5] and [Former Staff #10] punching [Former Staff #10]. [Former Staff #10] pushed consumer back into the room. The Consumer was warned that he would be put in a hold which decreased the consumer back into the room. The consumer was warned that he would be put in a hold which decreased the consumers aggression. The [Clinical Director] placed the consumer on suicide precautions at 3:34pm for self-injurious behavior. The consumer is under close supervision and in a paper gown for safety."

Interview on 4/27/22 with Former Client #1 revealed:
-He was in his room due to his behaviors.
-He became upset and threw his clothes at staff and hit staff.
-Staff pushed him against the wall with his body.
-He stated his arm hit the door.
-There were other staff and a nurse present.
-One of the staff got the staff off him on the wall.
-He had a scar on the top of his left shoulder after the incident.

Interview on 4/21/22 with Nurse #1 revealed:
-Client was being aggressive in his room.
-She made the call to use a two-person therapeutic hold.
-She was present along with Staff #1 and Staff #5.
-She saw [Former Staff #10] push client back into

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room and didn't look aggressive.
-Once client calm, she returned to nurses' station.

Interview on 4/21/22 with Staff #5 revealed:
-He was called from other unit to assist with behavior.
-He witnessed client being walked down hallway with two staff and the nurse.
-Staff #1 and Former Staff #10 were trying to process with client and he started throwing basket and clothing.
-Nurse #1 instructed staff to remove items from room.
- Former Staff #10 leaned down to pick up clothing and client hit staff in face with a closed fist.
-Former Staff #10 grabbed client not therapeutically.
-Nurse #1 requested I step in to assist once Former Staff #10 was removed from situation.
-Once client calm, he returned to his unit.

Interview on 4/13/22 with Clinical Director revealed:
-She did not recall getting a phone call regarding the incident.
-She did receive an email from the Qualified Professional and forwarded the email to receive update.
-Investigations are completed by the Quality Assurance/Quality Improvement Department.

Interview on 4/21/22 with the Quality Assurance Director revealed:
-She is not at facility daily and was only contacted to complete investigations.
-Received email from guardian on 3/14/22 and responded the same day.
-She completed the internal investigation.
-The findings determined staff administered an

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V 514	Continued From page 23 improper hold and prior to consent from the nurse. -She provided mom email summary of the investigation findings. -She confirmed staff was terminated for not following company policy regarding de-escalation techniques as trained.	V 514		