STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL047-1	58	B. WING		06/	16/2022
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CANYON	I HILLS TREATMENT	FACILITY		RDEEN ROAL			
	OLIMANA DV. OTA	TEMENT OF DEFICIE		D, NC 28376		PECTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 000 INITIAL COMMENTS		V 000					
A complaint and a limited follow-up survey for the Type A1 was completed on June 16, 2022. This was a limited follow-up survey, only 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility - Scope (V314) was reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility - Scope (V314). Complaints #NC00189307, #NC00189348, #NC00189586 and #NC00189652 were substantiated. Complaint #NC00189014 was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 PRTF-Psychiatric Residential Treatment Facility for Children and Adolescents. This facility is licensed for 24 and currently has a census of 19. The survey sample consisted of audits of 4 current clients and 1 former client.							
V 314	27G .1901 Psych R	•	Scope	V 314			
	10A NCAC 27G .19 (a) The rules in this residential treatment (b) A PRTF is one or adolescents who substance abuse/deinpatient setting. (c) The PRTF shall environment for chinot meet criteria for require supervision on a 24-hour basis. (d) Therapeutic integrational deficits a adolescent's diagnostic in the control of the	s Section apply to the facilities (PRT) that provides can have mental illustration and provide a structure or adolescent and specialized erventions shall associated with the section of the facilities of the fac	F)s. re for children ness or non-acute tured living ents who do care, but do interventions address ne child or				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL047-15	8	B. WING		06/	16/2022
	PROVIDER OR SUPPLIER N HILLS TREATMENT	FACILITY	769 ABEF	DRESS, CITY, S RDEEN ROAL D, NC 28376	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 314	Continued From patreatment and specimental health thera therapeutic interver designed to addres necessary to facilitate community setting. (e) The PRTF shall for whom removal from to facilitate treatme (f) The PRTF shall individuals and age adolescent's catchr (g) The PRTF shall the following; Joint of Healthcare Organ Accreditation of Recouncil on. Accreditation of Re	peutic care. The peutic care. The ntions and services the treatment nate a move to a less of the treatment of the form home or a residential setting nt. coordinate with a coordinate with a coordinate within the commission on A commission or other nates set forth in the Clinical Policy Natial Treatment Fant amendments a colicy Number 8D Division of Medicial	ese es shall be eeds ess intensive er adolescents is essential other child or erough one of accreditation estimates; the ational endition of umber 8D-1, acility, and editions.	V 314			
	This Rule is not me Based on record re failed to ensure (a) therapeutic care de treatment needs ne a less intensive cor audited clients (#1) with other individua	view and intervie clients received signed to addres ecessary to facilite nmunity setting for and (b) failed to	ws the facility mental health s the ate a move to or 1 of 5 coordinate				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL047-158	B. WING		06/1	6/2022
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CANYON HI	ILLS TREATMENT	FACILITY	RDEEN ROAL 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
A. re -A - Di Di Di T fo se of se ara in evo no Ri re -I - T - T in In -L Si -T V - F ar - S th	Review on 6/14/2 evealed: Age: 12 Admission date of a Diagnoses of Attentisorder, Combined effant Disorder. Treatment Plan datablowing goals: -"[Client #1] will exual behaviors by fender education a essions while combined activities which and socially appropriate by progressores." eview on 6/14/22 of evealed the following dividual therapy of evealed the following had activities which and socially appropriates." eview on 6/14/22 of evealed the following had activities which and individual therapy of evealed the following had activities which activities which had the every on 6/14/22 of evealed the had the event on 6/14/22 of evealed therapy of event on 6/14/22 of event on 6/1	and #2). The findings are: 22 of Client #1's record 2/19/21. Ition-Deficit Hyperactivity If Type and Oppositional Ited 5/25/22 included the eliminate all inappropriate If actively engage in sex If and mental health therapy If pleting clinical assignments If address healthy boundaries If address healthy boundaries If address healthy boundaries If address healthy boundaries If a behaviors through If a therapy activities as If a therapy activities as If a therapy Notes If a therapy	V 314			

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STATE FORM 6899 7C0Y11 If continuation sheet 3 of 16

DIVISION	of Health Service Re	eguiation					
	IT OF DEFICIENCIES		R/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFIC	CATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL04	17-158	B. WING		06/1	6/2022
NAME OF T	PROVIDER OR SUPPLIER			DRESS CITY O	STATE, ZIP CODE		
INAIVIE OF F	NOVIDER OR SUPPLIER						
CANYON	I HILLS TREATMENT	FACILITY		DEEN ROAI			
), NC 28376			
(X4) ID	SUMMARY STA (EACH DEFICIENCY	TEMENT OF DE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG	REGULATORY OR L			PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
V 314	Continued From pa	ge 3		V 314			
V 014	·	_		V 014			
	-He had family therapy a little while ago.						
	-"I only had it once, but I want it."						
	-He started receiving		tor sexual				
	behavior with curren		ha muasilar:-				
	-Workbook provide	a to nim by ti	ne previous				
	Clinical DirectorHe had to read and	d anawar au	actions from the				
	workbook.	a answer que	estions nom the				
	-He did not underst	and the less	one in the				
	workbook.	and the less					
	-Sometimes it is rev	iewed by the	e theranist				
	"whenever he gets		o triorapiot,				
	J						
	Interview on 6/15/22	2 with the Th	erapist revealed:				
	-He started about 2						
	-He had no formal of	clinical trainir	ng specializing in				
	sexual behaviors.						
	-The previous clinic	al director p	rovided clients the				
	workbook.						
	-He printed pages f		kbook and				
	reviewed with client						
	 -He worked 2-3 day Saturday and Sund 		week but mostly				
	-He was not full-tim						
	-For the past 2-3 m		used on individual				
	therapy.		acca on marriada				
	-There was no othe	r therapist w	hen he took the				
	job.	-1					
	-He just start workir	ng on inappro	opriate sexual				
	behaviors with clien		-				
		_					
	Interview on 6/15/22	2 with the Cli	inical Director				
	revealed:	,	1/00/00				
	-She started as the						
	-The therapist work						
	professional before	sne got ther	e and racilitated				
	group therapyThe first week of M	1av 2022 tha	company let go				
	two contract therap		company let go				
	-The company did r		er that they were				
	The company did i		n machicy word				

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	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BUILDING:			
		MHL04	7-158	B. WING		06/1	16/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CANYON	I HILLS TREATMENT	EACILITY	769 ABER	DEEN ROA	D		
CANTON	THILLS TREATMENT	IACILITI	RAEFORI	O, NC 28376			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 314	Continued From pa	ge 4		V 314			
V 314	Continued From pare letting go the therapy and a therapy and a sunday. -She requested that but was deniedShe also requested management with respect to the sunday and a su	pists. Ently worked State the therapis of for a special or response. 2 of Client #1 2/19/21. Intion-Deficit Hod Type and Otted 5/25/22 in I lean and important and increasing the frequency and increasing the frequency and mental hopleting clinical address hear interapy active behavior therapy active the pleting clinical address hear interapy active the pleting clinical address hear interapy active therapy active therapy active therapy active the special pleting clinical address hear interapy active the special pleting clinical pleting clinical address hear interapy active the special pleting clinical pleting clinica	t worked full-time dized therapist to I's record Iyperactivity ppositional ncluded the clement usive unwanted acting out" implement jies by reducing ng coping skills ency of his anger nappropriate age in sex ealth therapy al assignments olithy boundaries rs through vities as	V 314			
	-Child/Family Team	Meeting date	ed 5/25/22.				
	Review on 6/14/22 revealed following: -Individual therapy -Group therapy 3/8	on 4/11/22, 5/	/7/22 and 5/14/22				

Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ' '	LE CONSTRUCTION :	(X3) DATE COMF	SURVEY
				·		
		MHL047-158	B. WING		06/1	16/2022
NAME OF	PROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY,	STATE, ZIP CODE		
CANYON	I HILLS TREATMENT	FACILITY	ABERDEEN ROA EFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 314	-Psychological eval 5/27/22There was no evid evaluation was requesting minutes. Interview on 6/14/2-Last time he had the SaturdayThe therapist did neworked with the therapist did neworked with the therapistPreviously receive a weekHe had family thereI only had it once, he started receiving behavior with curre workbook provide Clinical DirectorHe had to read and workbookHe did not underst workbookSometimes it is regulated.	nily sessions. ssions focused on al behaviors. of Client #1's record reveal duation request submitted lence in the record that luested in previous CFT 2 with Client #1 revealed: herapy was either Sunday not work full-time. herapist for about 2-3 weel about his anger managem of group therapy with the d therapy at least one or to apy a little while ago. but I want it." hig treatment for sexual nt therapist. d to him by the previous of answer questions from the rand the lessons in the viewed by the therapist, time." psychological evaluation.	ks. nent wice			
	-He started about 2	2 with the Therapist revea 2-3 weeks ago as the thera clinical training specializing	apist.			

Division of Health Service Regulation

STATE FORM 6899 7C0Y11 If continuation sheet 6 of 16

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL047-158	B. WING		06/1	6/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CANYON	N HILLS TREATMENT	FACILITY	RDEEN ROAI D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 314	Continued From pa	age 6	V 314			
	workbookHe printed pages to reviewed with clienter -He worked 2-3 day Saturday and Sunder -He was not full-time. For the past 2-3 metherapyThere was no other jobHad a good relation -He just start working behaviors client #1 Interview on 6/14/2 Professional reveates -She submitted referon 5/27/22The location of the client #1's insurance.	ys out of the week but mostly lay. ne. nonths he focused on individual er therapist when he took the onship with the clients. ng on inappropriate sexual . 2 with the Qualified led: erral for psychological testing er test was not covered under se. he process for searching for				
	Interview on 6/15/22 with the Clinical Director revealed: -She started as the clinical director on 4/29/22The therapist worked as the qualified professional before she got there and facilitated group therapyThe first week of May 2022 the company let go two contract therapistsThe company did not inform her that they were letting go the therapistsShe immediately had the QP become the individual therapistThe Therapist currently worked Saturday and SundayShe requested that the therapist worked full-time but was denied.					

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STATE FORM 6899 7C0Y11 If continuation sheet 7 of 16

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL047-158	B. WING		06/1	6/2022
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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 314	Continued From pa	ge 7	V 314			
	-The new QP started April 2022Previous QP was I 2022Aware the psychol submittedUnaware the psychol due to his insuranceShe started particidue to prior issues Review on 6/14/22 -Age 14Admission date of	ed towards the middle to end of et go for no reason in April ogical evaluation request was nological location was denied e. pating in the CFT meetings and concerns.				
	Recurrent, Severe;	Attention Deficit Hyperactivity d Type and Sibling Relational				
	Interview on 6/14/22 with Client #2 revealed: -Last court appearance was June 10thHe did not miss a court dateSpoke to court counselor about once every two weeksThe Qualified Professional did not tell him he missed a call from his court counselorHe was not aware that he was supposed to call his court counselor back.					
	-She had a meeting callShe would call the permittedShe did not ask ar counselor back.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL047-158	B. WING		06/	16/2022
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE		
CANYON	N HILLS TREATMENT	FACILITY	ABERDEEN ROA FORD, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 314	-She emailed the coubut she felt ill and heshe called the coushe did not inform supervisorShe did not ask the else to ensure client counselorShe later discusse about scheduling planterview on 6/15/22 revealed: -During the child/farstakeholders reported she gave the stake-The court counselorShe apologized to she gave the stake-The court counselor experienced with the the concerns we respondShe asked the QP stakeholdersQP reported she we because she don't the the court court she we cause she don't the the the court courselors.	purt counselor the next day ad to go to urgent care. It counselor the following of the clinical director her expected called his court downth the court counselor mone calls. With the Clinical Director mily team meeting the expected problems with the QP. the stakeholders her direct number or reported everything she expected and the QP did to the counter of the QP. The counter of the QP did to the CP did to the counter of the QP did to the CP did to the C	day.			
V 316	10A NCAC 27G .19 (a) A PRTF may ha unit. Each unit of a than 12 children or in Paragraph (b) of unit shall be admini	Res. Tx. Facility - Operation O3 OPERATIONS ave more than one residen PRTF shall serve no more adolescents except as set this Rule. Each residentia stered, staffed, and locate from all other residential u	tial e out I d to			

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL047-	158	B. WING		06/	16/2022
	PROVIDER OR SUPPLIER N HILLS TREATMENT	FACILITY	769 ABEF	DRESS, CITY, S RDEEN ROAD D, NC 28376	TATE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EIENCIES DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 316	(b) A facility license with a unit capacity effective date of the provide these service and may continue to greater capacity. (c) Discharge plant admission. Efforts restrictive commundocumented from to the child or adolesced discharge planning. (d) Each facility shows even days a week. (e) Family member persons shall be invimplementation of the assure a smooth transcriber. (f) Children or adolesced facility-based school meet applicable state and State law. (g) Each child or an age-appropriate perentitlement is country plan.	ed to provide Plof greater than ese Rules may ces at that greater than the determinant of the determinant plans ansition to a less that greater than the determinant plans ansition to a less that greater than the determinant plans and each that greater than the determinant plans ansition to a less that greater than the determinant plans and greater than the determinant plans and greater than the determinant plans and greater than the determinant plans are greater than the greater than the determinant plans are greater than the determinant plans are greater than the greater tha	a 12, as of the continue to ater capacity nse at that an on the day of o a less etting shall be ission. Legally pers or both and esent at anours a day, of the year. Illy responsible evelopment and in order to as restrictive ag in a PRTF through a services shall uired by federal be entitled to ags unless such the treatment	V 316			
	This Rule is not me Based on record re failed to ensure dis- date of admission to residential setting a	view and interv charge planning o a less restrict	riews the facility g began on the tive community				

6899

Division of Health Service Regulation STATE FORM

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION		E SURVEY PLETED
		MHL047-158	B. WING		06/	16/2022
	PROVIDER OR SUPPLIER N HILLS TREATMENT	FACILITY 769 ABER	DRESS, CITY, ST RDEEN ROAD D, NC 28376	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
V 316	from the date of ad clients (#1 and #2). Review on 6/14/22 -Age: 12 -Admission date of -Diagnoses of Atter Disorder, Combine Defiant DisorderTreatment Plan da following goals: -"[Client #1] will sexual behaviors by offender education sessions while com and activities which and socially appropindividual and grou evidence by progre notes." Review on 6/14/22 revealed following: -Individual therapy 5/14/22Group therapy 3/8 -There were no fan -There were no ses inappropriate sexual Review on 6/14/22 Team Meeting Minuthe following: -"[Client #1] will elimbehaviors by active education and men while completing clactivities which add socially appropriate sexual socially appropriates."	mission for 2 of 5 audited of Client #1's record revealed: 2/19/21. ntion-Deficit Hyperactivity d Type and Oppositional ated 5/25/22 included the I eliminate all inappropriate y actively engage in sex and mental health therapy pleting clinical assignments address healthy boundaries oriate behaviors through p therapy activities as ss documented on clinical of Client #1's Therapy Notes on 4/11/22, 5/7/22 and 8/22, 3/24/22 and 3/25/22. nily sessions. esions focused on	V 316			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL047-158	B. WING		06/	16/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
CANYO	N 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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 316	progress document -"[Client #1's] le about [Client #1's] le mother shared that positive behaviors value something and [Clie [Client #1's] mother with [Client #1] retu current state [Client "We discusse level 4 that specializ behavior (the behav placement in a psyc facility - in order to le the team will need t -Updated a Plan; -An updated assessmentUpdated p (referral to services -All updated records." -There was no evid information in the re -The discharge crite minutes was blank. Interview on 6/14/2: Professional reveal -She was responsit -She would send re for clientsShe did not receive 2022There was a previo	red on clinical notes." regal guardians are concerned ack of progress. [Client #1's] [Client #1] is able to show when [Client #1] wants rent #1] is very manipulative. I stated she does not feel safe rning to her home in the training training to her home in the training tra	V 316			

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
MHL047-158			B. WING			06/16/2022			
NAME OF	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 STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
V 316	Continued From pa Interview on 6/15/2: revealed: -She started as the -Client #1 was curre -Planning to submit -She was willing to client #1 to be step -She did an addend send referrals for a -She did not receive statusClient #1's next ch on 6/23/22Client #1's step do during the next CFT Review on 6/14/22 -Age 14Admission date of -Diagnoses of Majo Recurrent, Severe; Disorder, Combined Problem. Review on 6/14/22 Application for Clier -There was no sign Legally Responsible -There was no sign Clinical DirectorThere was a signa Professional. Review on 6/14/22 Emails with Reside Source from May 9 revealed: -5/9/22 - "[QP's] apr Former Therapist a longer with our age	Clinical Director Clinical Director Clinical Director Programme to the Pro	or on 4/29/22. discharged. el III. mendation for met the criteria. or the QP to teral move. In the QP on the meeting was discord revealed; discorder, it Hyperactivity ing Relational cial Treatment 2/22 revealed: ral by the ral by the ral by the ral by the ral country and professional Referral 2, 2022 double referral. ector are no	V 316					

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PRINTED: 06/21/2022 FORM APPROVED

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ווטופועום	of Health Service Re	egulation	1			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:		COMPLETED	
MHL047-158		B. WING		06/16/2022		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TO WILL OF T	NOVIBER OR SOLVER		RDEEN ROAI			
CANYON	I HILLS TREATMENT	FACILITY	D, NC 28376			
			1			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
V 316	Continued From pa	nge 13	V 316			
V 010	-		V 010			
		current clinical director and				
		ed professional who will handle				
		[QP] was unaware of a referral				
		s I was not working with				
	Canyon Hills at the					
		epresentative: "At this time,				
		if we could schedule a				
	convenient time to have the clinical conversation.					
	[Referral Representative] can arrange it during					
	much of tomorrow after 9:30 a.m. If not tomorrow,					
	then [Referral Representative] have open times					
	on Friday after 9 a.m. in between (Wednesday					
	and Thursday). It might be challenging as there are already several things scheduled. Or we can					
		Look forward to response." an email to the referral				
		attachments of client #2's				
		ational Plan and Diagnostic				
	and Clinical Assess					
		representative email to the QP				
		oid further delay in having				
		I reviewed, [Referral				
		I share it with one of the				
		mbers. As [Referral				
		spected, the information that				
	has been sent indic	ates a lack of progress at				
		ing behavior problems with				
	aggression and hig	h-intensity outburst, lack of				
	engagement in trea	tment, etc. The note from				
	[Therapist] was sha	ared did reflect information				
		y; some reference to some				
	progress, but no iss	sues related to Problematic				
		ut the UA and PCP and				
		nical Assessment all reference				
		ick of progress and ongoing				
		problems. If [QP] want to				
		an accurate review of this				
		will need to send documents				
		2's] progress, lack of ongoing				
	aggression/outburs	t, engaging in individual/group				

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	Ul Health Service IN		(A(C) 141 II TIBL	E CONCEDUCTION	Torri Date	OLIDY (E) (
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND I EAN OF CONNECTION		A. BUILDING:			OCIVIF LL I LD	
		D W/WG				
MHL047-158			B. WING		06/1	6/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CANIVON	N HILLS TREATMENT	769 ABER	DEEN ROAL	D		
CANTO	I HILLS I REALIVIENT	RAEFORI	O, NC 28376	3		
(X4) ID	=	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	NEODEATORT OR E	OCIDENTII TING INI CHWATION)	TAG	DEFICIENCY)	INAIL	57.11.2
V 24C	0	44	V 24C			
V 316	Continued From pa	ge 14	V 316			
	therapy, etc. [Refe	rral Representative] know that				
		notes reflecting progress in				
		s been indicated that [Client				
		guardian] only had 1 session				
		placement at Canyon Hills.				
		rral Representative] on #21 had progress to				
	5/10/22 that [Client #2] had progress to "apology/reconciliation" phase of treatment-but					
	that information has not been sent to us at this					
	time." -5/16/22 - QP sent an email to the referral representative with an attachment of client #2's Person Centered Plan.					
	-There was no additional information sent per					
	request from the referral representative to show					
	client #2's progress.					
	Interview on 6/14/22 with Client #2 revealed:					
		to step down to a level III.				
		t accepted because "I didn't				
	talk enough, and m					
		eople, that's mainly it and				
	aggressiveness."					
		zed to his sister before his eatment about one year ago.				
	ilist admission to th	earment about one year ago.				
	Interview on 6/14/2	2 with the Qualified				
	Professional reveal					
	-Client #2's guardia	n requested level III				
	placement.					
		remember when the request				
	was made.					
	-She received a for					
	call.	e wanted to do a clinical phone				
		ral source client #2's Person				
		sessment via email.				
	-There was an ema					
		ors did not constitute a level III.				
		t #2's behavior was the reason				

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 316 Continued From page 15 for denial. -Sent referral on 5/9/22 and they wanted her to update it. -She reported that client #2 was going to apologize to his sister in a letter. -The family would not get that letter; it was for therapy. -The idea came from the previous therapist. -The workbook was provided before she started working at the facility. -She had no specialized no training with sexually aggressive adolescents.	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 T69 ABERDEEN ROAD RAEFORD, NC 28376 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 316 Continued From page 15 for denial. -Sent referral on 5/9/22 and they wanted her to update it. -She reported that client #2 was going to apologize to his sister in a letter. -The family would not get that letter; it was for therapy. -The idea came from the previous therapist. -The workbook was provided before she started working at the facility. -She had no specialized no training with sexually aggressive adolescents.	MHL047-158		B. WING		06/16/2022		
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 316 Continued From page 15 for denial. -Sent referral on 5/9/22 and they wanted her to update itShe reported that client #2 was going to apologize to his sister in a letterThe family would not get that letter; it was for therapyThe idea came from the previous therapistThe workbook was provided before she started working at the facilityShe had no specialized no training with sexually aggressive adolescents.	NAME OF PROVIDE	IDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 316 Continued From page 15 for denial. -Sent referral on 5/9/22 and they wanted her to update it. -She reported that client #2 was going to apologize to his sister in a letter. -The family would not get that letter; it was for therapy. -The idea came from the previous therapist. -The workbook was provided before she started working at the facility. -She had no specialized no training with sexually aggressive adolescents.	CANYON HILLS	LS TREATMENT	FACILITY				
for denialSent referral on 5/9/22 and they wanted her to update itShe reported that client #2 was going to apologize to his sister in a letterThe family would not get that letter; it was for therapyThe idea came from the previous therapistThe workbook was provided before she started working at the facilityShe had no specialized no training with sexually aggressive adolescents.	PRÉFIX (E	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
-She only worked in case managementRequest for level III was made early per guardianIn January a referral was sent to the level IIIClient #2 was denied due to un-going aggressionReceive email on 5/16/22 that client was not accepted for Level III. Interview on 6/15/22 with the Clinical Director revealed: -QP sent documents to get client #2 stepped down to a level IIIShe did not know the QP was doing thisQP had to follow her lead in far of recommendationsThe QP took it upon herself to send over paperworkShe told the QP she should not send paperwork without her approvalThe court counselor and client #2's mother was highly upsetClient #2 did not meet the criteria.	for de-Sent updat -She apolo -The thera -The worki -She aggre -She -Requiguard -In Ja -Clier aggre -Rece accept Interview -QP s down -She -QP h recon -The paper -She witho -The highly	denial. ent referral on 5/s date it. he reported that o logize to his sishe family would recapy. he idea came from the workbook was rking at the facility he had no special gressive adolescence only worked in equest for level II ardian. January a referrient #2 was denigression. He did not know the cepted for Level erview on 6/15/20/ evealed: P sent document with the allow the commendations. The did not know the commendations of the QP shout her approve the court counseled the court counseled the provent.	9/22 and they wanted her to client #2 was going to ster in a letter. not get that letter; it was for om the previous therapist. It is provided before she started ity. It is a management. It is made early per ral was sent to the level III. It is due to un-going 15/16/22 that client was not III. It is to get client #2 stepped 11. I	V 316			

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