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CANYON HILLS TREATMENT FACILITY	769 ABERDEEN ROAD RAEFORD, NC 28376

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V 000	INITIAL COMMENTS A complaint survey was completed on June 9, 2023. Two complaints were substantiated (NC00200967, NC00202591). Three other complaints were unsubstantiated (NC00202867, NC00202906, NC0020323). 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 18. The survey sample consisted of audits of 4 current clients and 2 former clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include:	V 105		

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V 105	Continued From page 1 (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record reviews and interviews the governing body failed to ensure their incident reporting system was followed and failed to implement policies to assure their operational and programmatic performance was meeting applicable standards of practice. The findings are:

Review on 5/31/23 of the Code of Federal Regulations (CFR) revealed
-"§483.374(b) Reporting of serious occurrences... (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than the close of business the next business day after a serious occurrence..."

Review on 5/31/23 of the LME-MCO (Local Management Entity-Managed Care Organization) communication Bulletin J287, "Clarifying the Reporting Standards for Psychiatric Residential Treatment Facilities (PRTF)" dated 5/11/18 revealed:
-" ...Serious Occurrences are any event that result in Restraint or Seclusion, Resident's Death, Any Serious Injury to a Resident, and a Resident's Suicide Attempt. NC § 483.374 specifies that facilities must report each Serious Occurrence to both the State Medicaid Agency (Division of Medical Assistance - DMA)..." "DMA

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V 105	Continued From page 3	V 105		

receives report of Serious Occurrences via the Incident Response and Improvement System (IRIS) managed by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services ..." "DRNC reports are to be faxed to (919) 856-2244."

Refer to tag V367 in regards to the 5/17/23 incident that occurred at the facility.

Review on 5/25/23 of an internal investigation completed by the Program Director on 5/17/23 revealed:
-Detailed Narrative of How Incident Occurred: "On May 17, 2023, the Nurse came into Clinical Office and informed the Qualified Professional that she witnessed a staff slap a consumer. The Program Director unaware walked into the clinical office and was informed by the Nurse that she physically witnessed a staff slap a consumer. The Program Director inquired who the staff and the consumer were. The Nurse indicated that the staff was [former staff #8 (FS #8)] and the consumer was [former client #6 (FC #6)]..."

Reviews on 5/25/23, 5/31/23 and 6/9/23 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-There was no level III incident report submitted by the facility for the allegations of abuse that occurred on 5/17/23.
-There was no documentation that indicated DRNC was informed about the above allegation of abuse.

Interview on 5/31/23 with the Qualified Professional revealed:
-The nurses were responsible for submitting IRIS reports.
-She did not know if DRNC had been notified.

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V 105	Continued From page 4 Interview on 5/31/23 with the Nurse revealed: -She acknowledged seeing FS #8 slap FC #6. -She reported the incident to the Qualified Professional and the Program Director. -Nurses submitted incident reports to IRIS. -She had made an incident report about FC #6 regarding event on 5/17/23. -Corporate was responsible for submitting reports to other agencies such as DRNC. -She did not know if DRNC had been notified about the incident on 5/17/23. Interview on 5/31/23 with the Program Director revealed: -On 5/17/23, she had been informed by the Nurse that FC #6 had said that FS #8 had hit him. -Corporate compliance was responsible for completing reports to Disability Rights. She was not sure if they had reported the allegation. Interview on 5/31/23 with the Corporate Compliance Officer revealed: -She informed that "a lot of things that were supposed to be done, were not completed." -She acknowledged the facility had not followed procedures in reporting the incident of abuse that occurred on 5/17/23. -Facility had not comply with DRNC reporting requirements. -DRNC had not been notified of the allegation of abuse that occurred on 5/17/23.	V 105		
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	V 132		

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V 132	Continued From page 5 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 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.	V 132		

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V 132	Continued From page 6	V 132		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure an allegation of abuse was reported to the Health Care Personnel Registry (HCPR) within five working days. The findings are:

Review on 5/25/23 of former staff #8 (FS #8) revealed:
-Hire date of 3/8/18.
-He was hired as a Residential advisor.
-Separation date of 5/17/23.

Refer to tag V367 in regards to the 5/17/23 incident that occurred at the facility.

Reviews on 5/25/23, 5/31/23 and 6/9/23 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-No level III report submitted by the facility for former client #6 (FC #6) for the alleged incident of abuse which occurred on 5/17/23.
-There was no evidence that FC #8's name had been reported to HCPR.

Interview on 5/31/23 with the Qualified Professional revealed:
-There was an allegation made that FS #8 had slapped FC #6 in the face.
-Nurses were responsible for submitting IRIS reports, but corporate was responsible for submitting reports to other agencies.
-She was not sure if FS #8's name had been reported to HCPR.

Interview on 5/31/23 with the Nurse revealed:

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V 132	Continued From page 7 -She acknowledged seeing FS #8 hitting FC #6. -Nurses were responsible for submitting IRIS reports. -Corporate was responsible for submitting reports to HCPR. -She was not sure if FS #8's name had been reported to HCPR. Interview on 5/31/23 with the Program Director revealed: -On 5/17/23, she had been informed by the Nurse that FC #6 had said that FS #8 had hit him. -Corporate was responsible for submitting reports to HCPR. -She was not sure if FS #8's name had been reported to HCPR. Interview on 5/31/23 with the Corporate Compliance Officer revealed: -FS #8 had been suspended. Recommendation was for termination of employment. -FS #8 failed to follow de-escalation procedures or let clinical staff intervene and should not had stepped in. -She acknowledged the facility had not followed procedures in reporting the incident. -She informed that "a lot of things that were supposed to be done, were not completed." -She acknowledged facility failed to report FS #8's name for the allegation of abuse that occurred on 5/17/23 to HCPR within five working days.	V 132		
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	V 314		

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V 314	Continued From page 8 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 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/.	V 314		

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V 314	Continued From page 9	V 314		

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to coordinate client care with other individuals and agencies affecting one of six audited client (#1). The findings are:

Review on 5/25/23 of client #1 (CL #1)'s record revealed:
-Admission date of 10/11/22.
-Diagnoses of Oppositional Defiant Disorder; Posttraumatic Stress Disorder; Conduct Disorder Unspecified Onset.
-He was 13 years old.

Review on 6/2/23 of CL #1's Child & Family Team (CFT) Meeting Minutes for the months of April 2023 through May 2023 revealed:
-The April meeting was conducted on 4/6/23. Month of March was reviewed. Legal guardian was in attendance via video.
-Plan of care for continued stay was discussed.
-There were three level I incidents reported.
-CL #1's strengths were reported.
-Concerns/Behaviors for the month were informed. Behaviors were dated and gave brief explanation of what occurred. On 3/30, CL #1 was placed on suicidal watch.
-May's meeting was conducted on 5/3/23. Month of April was reviewed. Legal guardian was in attendance via video.
-Plan of care for continued stay was discussed.

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V 314	Continued From page 10 -There were three level I incidents and one level II incident reported related to an injury on his arm while playing basketball. -CL #1's strengths were reported. -Concerns/Behaviors for the month reported. Client #1 was not placed on suicidal watch for the month of April. -Client #1's record did not contain CFT meeting minutes for the months of January and February. It is unknown at this time if meetings were conducted. Review on 5/25/23 of a therapy note for CL #1 dated 3/1/23 revealed: -Note was completed by the Therapist. -Description of Intervention/Activity: "In the course of the past month, [CL #1] has had several incidents where he verbalized feelings of harm. He was placed on suicide watch. The therapist met with [CL #1] and explored the possible triggers associated to his feelings. [CL #1] has explained that he often desires attention during those times..." Review on 5/25/23 of a safety plan for client #1 revealed: -Plan was dated 4/18/23. Additional Safety Outcomes: "1. Guardian will be notified of any incidents or injuries within a 24 hour timeframe. 2. Guardian will be notified of any investigations pertaining to [CL #1] and it's findings at the conclusion of the investigation. 3. Guardian will be notified of suicide watch immediately." Review on 6/2/23 of electronic mails (emails) communications between CL #1's legal guardian and the Qualified Professional (QP)revealed: -There were communications between the two parties on the following dates:	V 314		

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V 314	Continued From page 11 -3/14/23, 3/15/23, 3/19/23, 3/23/23, 3/28/23, 4/4/23, 4/5/23, 4/6/23, 4/17/23, 4/24/23, 5/1/23, 5/2/23, 5/5/23, 5/9/23, 5/10/23, 5/11/23, 5/17/23, 5/19/23, 5/21/23, 5/22/23 and 5/31/23. -There were no records of communications between the QP and CL #1's legal guardian from the months of January and February. Interview on 6/5/23 with CL #1's Department of Social Services (DSS) legal guardian revealed: -She had been trying to get information about CL #1's incidents from January 2023 where he had gotten into a couple of fights with two other clients at the facility as well as being placed on suicide watch. -She had found out from CL #1's mother as he had informed her about the incidents. -She had never received any communication about this incidents. -She needed this information to place them in his folder. She had been asking about them, but facility had not provided the information. -She had received information at the CFT meetings at the beginning of March and May. -She acknowledged that communication with facility had improved since beginning of May, but she still needed the requested documentation. Interview on 6/2/23 with the QP revealed: -She started working at the agency in February of 2023. -Former QP left around March of 2023. -Former QP's electronic mails (emails) were de-activated. Facility was unable to retrieve any communication between the QP and CL #1's legal guardian. -Starting in April 2023, she had extensive communications via emails with CL #1's legal guardian. -She knew that during the CFT Meetings, they	V 314		

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V 314	Continued From page 12 discussed all issues regarding clients to their guardians and other members of the team. -During CFT, they talked about needs, behaviors, medications, educational, discharges among other things that may had come up that month. -The CFT forms or minutes are not shared with client's guardians. -She was aware that CL #1 had been assigned a new person to be his legal guardian's representative. -Facility also had a new QP that just started last month. CL #1 was now under her casework at the facility. -She was also aware that CL #1's therapists at the facility also communicated directly with his legal guardian. -She acknowledged that there were no records of communication between the facility and CL #1's legal guardian regarding issues related to him getting into a fight with two other clients in January and about him being placed on suicide watch. No documentation was provided by the facility regarding communication between CL #1's legal guardian and the facility about incidents occurred in the months of January and February of 2023. CL #'1's legal guardian had been requesting information about CL #'1's fights with others and of being placed on suicide watch in order to continue to coordinate care. Facility had not been able to provide them.	V 314		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and	V 366		

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V 366	Continued From page 13 implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and	V 366		

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V 366	Continued From page 14 (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to	V 366		

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V 366	Continued From page 15 Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to implement a written policy governing their response to level III incidents as required and to ensure all entities were notified. The findings are: Refer to tag V367 in regards to the 5/17/23 incident that occurred at the facility. Review on 5/25/23 of an internal investigation completed by the Program Director on 5/17/23 revealed: -Detailed Narrative of How Incident Occurred: "On May 17, 2023, the Nurse came into Clinical Office and informed the Qualified Professional that she witnessed a staff slap a consumer. The Program Director unaware walked into the clinical office and was informed by the Nurse that she physically witnessed a staff slap a consumer. The Program Director inquired who the staff and the consumer were. The Nurse indicated that the	V 366		

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V 366	Continued From page 16 staff was [former staff #8 (FS #8)] and the consumer was [former client #6 (FC #6)]..." Reviews on 5/25/23, 5/31/23 and 6/9/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No IRIS report, Risk/Cause Analysis, or documentation to support submission of written preliminary findings of fact to the Local Management Entity (LME)/Managed Care Organization (MCO) within 5 working days for the allegation of abuse which occurred on 5/17/23. Interview on 5/31/23 with the Corporate Compliance Officer revealed: -She acknowledged the facility had not followed procedures in reporting the incident. -Facility had not reported preliminary findings on IRIS the allegation of abuse which occurred on 5/17/23.	V 366		
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 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	V 367		

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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 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

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V 367	Continued From page 18 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: Based on record review and interview the facility failed to ensure all Level III incidents were completed and submitted to the Local Managed Entity/Managed Care Organization (LME/MCO) within 72 hours. The findings are: Review on 5/31/23 of an internal incident report	V 367		

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V 367	Continued From page 19 dated 5/17/23 revealed: -Completed by the Nurse. -Categorized as a Level I. -"At approximately 2:30 pm the nurse went onto the unit to do shift rounds. Staff addressed the nurse about [Former client #6 (FC #6)]'s 2:00 pm medication and the nurse went down the hall to the consumer's room to let him know that it was time for his medication. [FC #6] is observed being verbally and physically aggressive to the Residential Advisor that was processing with him (former staff #8 (FS #8)). The consumer is observed getting into staff's personal space and hitting staff. The consumer is asked why he is so angry he says because nobody has the right to hit me. The consumer is offered his "As Needed Medications"(PRN) but refuses. The consumer continues to escalate further so staff is directed by the nurse for additional assistance. [FS #8] is asked to switch out since he is the focus of the consumer's aggression. The consumer continues to display physical aggression by punching his window and his wall stating "It's not fair to let me get hit like that, I'll blow this whole place up." The consumer processes with staff until he is calm enough to take his scheduled medication. This nurse and staff will continue to monitor the consumer and the consumer's status throughout shift." -Incident report did not make mention of FS #8 actually hitting FC #6. -Report should have been categorized as a level III incident due to the allegation of abuse of former staff #8 towards former client #6. Review on 5/25/23 of an internal investigation completed by the Program Director on 5/17/23 revealed: -Detailed Narrative of How Incident Occurred: "On May 17, 2023, the Nurse came into Clinical	V 367		

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V 367	Continued From page 20 Office and informed the Qualified Professional that she witnessed a staff slap a consumer. The Program Director unaware walked into the clinical office and was informed by the Nurse that she physically witnessed a staff slap a consumer. The Program Director inquired who the staff and the consumer were. The Nurse indicated that the staff was [FS #8] and the consumer was [FC #6]. The Program Director instructed the Nurse to provide details of what happened. The Nurse indicated that [FC #6] was having a behavior and she was called to the floor. The Nurse indicated that [FC #6] told her that he did not like blue and that he was going to rape her. The Nurse indicated that [FC #6] walked towards her, and [FS #8] intervened and allegedly pushed [FC #6] against the wall. [FC#6] allegedly smacked [FS #8]..." -"...Per report of of [FC #6], [FS #8] pushed [FC #6] against the wall and he smacked him. [FC #6] reported that [FS #8] was being aggressive with him, so he smacked him again. [FC #6]stated that he then tried to kick [FS #8] in the "nuts." [FC #6] reported that [FS #8] threw him against the other wall and was cursing at him..." -'...The Nurse reported that she attempted to get [FS #8] to disengage and requested another member of staff to switch with FS #8]. The Nurse reported that she witnessed [FS #8] slap [FC #6] while in crisis. The Nurse also reported that she witnessed [FS #8] with his hands around the consumer's neck while trying to get [FC #6] to back out of his personal space. The Program Director then notified the Facility Manager. Facility manager informed [FS #8] that he had to leave the facility based on the allegation made against him..." -"...[FS #8] stated that [former client #6] was in an uproar. [FC #6] was yelling, cursing and making threats to harm self and staff. [FS #8] reported	V 367		

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V 367	Continued From page 21 that the Nurse was called down and offered assistance to him and the other staff. [FS #8] stated that [FC #8] informed the Nurse that he disliked blue. The Nurse prompted [FC #6] to have a seat on his bed. [FC #6] charged at staff and violated boundaries. [FC #6] began to slap him about the head and face. [FS #8] reported that it was at that time that the Nurse requested staff to switch. [FS #8] then returned to the common area with the remaining consumers." Reviews on 5/25/23, 5/31/23 and 6/9/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -There was no documentation an incident report was completed by facility staff for the above issue. Interview on 5/31/23 with the Corporate Compliance Officer revealed: -She acknowledged the facility had not followed procedures in reporting the incident. -She acknowledged the incident dealing with the allegation of abuse from FS #8 towards FC #6 was not reported on IRIS. -She confirmed the facility failed to ensure the allegation of abuse dated 5/17/23 was reported to the LME/MCO within 72 hours of becoming aware.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that:	V 500		

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V 500	Continued From page 22 (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated	V 500		

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V 500	Continued From page 23 competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interviews, the governing body failed to report an allegation of abuse to the Department of Social Services (DSS). The findings are: Refer to tag V367 in regards to the 5/17/23 incident that occurred at the facility. Review on 5/25/23 of an internal investigation completed by the Program Director on 5/17/23 revealed: -Detailed Narrative of How Incident Occurred: "On May 17, 2023, the Nurse came into Clinical Office and informed the Qualified Professional that she witnessed a staff slap a consumer. The Program Director unaware walked into the clinical office and was informed by the Nurse that she physically witnessed a staff slap a consumer. The Program Director inquired who the staff and the consumer were. The Nurse indicated that the staff was [former staff #8 (FS #8)] and the consumer was [former client #6 (FC #6)].	V 500		

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V 500	Continued From page 24 Reviews on 5/25/23, 5/31/23 and 6/9/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -There was no level III incident report submitted by the facility for the above allegation of abuse. -There was no indication DSS was contacted about the above allegation of abuse. Interview on 5/31/23 with the Corporate Compliance Officer revealed: -She was responsible for submitting reports to the local county DSS. -She acknowledged the facility had not followed procedures in reporting the incident that occurred on 5/17/23. -She acknowledged the incident dealing with the allegation of abuse from former staff #8 towards FC #6 was not reported to the local DSS within the required amount of time.	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size	V 512		

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and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.
(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.

This Rule is not met as evidenced by:
Based on record review and interviews 1 of 2 audited former staffs (former staff #8 (FS #8)) subjected 1 of 2 audited former clients (former client #6 (FC #6)) to abuse. The findings are:

Review on 5/25/23 of FC #6's record revealed:
-Admission date of 9/20/22.
-Diagnoses of Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder.
-He was 13 years old.
-Discharge date of 5/18/23.

Review on 5/25/23 of FS #8 revealed:
-Hire date of 3/8/18.
-He was hired as a Residential advisor.
-Termination date of 5/17/23.

Review on 5/31/23 of an internal incident report dated 5/17/23 revealed:
-Completed by the Nurse.
-Categorized as a Level I.
-"At approximately 2:30 pm the nurse went onto the unit to do shift rounds. Staff addressed the nurse about [FC #6]'s 2:00 pm medication and the nurse went down the hall to the his room to let him know that it was time for his medication. The consumer is observed being verbally and physically aggressive to the Residential Advisor

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(RA) that was processing with him (FS #8). The consumer is observed getting into staff's personal space and hitting staff. The consumer is asked why he is so angry he says because nobody has the right to hit me. The consumer is offered as needed medications (PRN) but refuses. The consumer continues to escalate further so staff is directed by the nurse for additional assistance. [FS #8] is asked to switch out since he is the focus of the consumer's aggression. The consumer continues to display physical aggression by punching his window and his wall stating 'It's not fair to let me get hit like that, I'll blow this whole place up.' The consumer processes with staff until he is calm enough to take his scheduled medication. This nurse and staff will continue to monitor the consumer and the consumer's status throughout shift."
-Allegation should have been categorized as a level III incident.
-There was no evidence the facility submitted Level III report mentioned to the required reporting agencies.

Review on 5/25/23 of an internal investigation completed by the Program Director on 5/17/23 revealed:
-Detailed Narrative of How Incident Occurred: "On May 17, 2023, the Nurse came into Clinical Office and informed the Qualified Professional that she witnessed a staff slap a consumer. The Program Director unaware walked into the clinical office and was informed by the Nurse that she physically witnessed a staff slap a consumer. The Program Director inquired who the staff and the consumer were. The Nurse indicated that the staff was [FS #8] and the consumer was [FC #6]. The Program Director instructed the Nurse to provide details of what happened. The Nurse indicated that [FC #6] was having a behavior and

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V 512	Continued From page 27 she was called to the floor. The Nurse indicated that [FC #6] told her that he did not like blue (color) and that he was going to rape her. The Nurse indicated that [FC #6] walked towards her, and [FS #8] intervened and allegedly pushed [FC #6] against the wall. [FC #6] allegedly smacked [FS #8]..." -"...Per report of [FC #6], [FS #8] pushed [FC #6] against the wall and he smacked him. [FC #6] reported that [FS #8] was being aggressive with him, so he smacked him again. [FC #6] stated that he then tried to kick [FS #8] in the 'nuts.' [FC #6] reported that [FS #8] threw him against the other wall and was cursing at him..." -"...The Nurse reported that she attempted to get [FS #8] to disengage and requested another member of staff to switch with [FS #8]. The Nurse reported that she witnessed [FS #8] slap [FC #6] while in crisis. The Nurse also reported that she witnessed [FS #8] with his hands around the consumer's neck while trying to get [FC #6] to back out of his personal space. The Program Director then notified the Facility Manager. Facility manager informed [FS #8] that he had to leave the facility based on the allegation made against him..." -"...[FS #8] stated that [FC #6] was in an uproar. [FC #6] was yelling, cursing and making threats to harm self and staff. [FS #8] reported that the Nurse was called down and offered assistance to him and the other staff. [FS #8] stated that [FC #8] informed the Nurse that he disliked blue (color). The Nurse prompted [FC #6] to have a seat on his bed. [FC #6] charged at staff and violated boundaries. [FC #6] began to slap him about the head and face. [FS #8] reported that it was at that time that the Nurse requested staff to switch. [FS #8] then returned to the common area with the remaining consumers."	V 512		

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V 512	Continued From page 28 Reviews on 5/25/23, 5/31/23 and 6/9/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No IRIS report, Risk/Cause Analysis, or documentation to support submission of written preliminary findings of fact to the Local Management Entity (LME)/Managed Care Organization (MCO) within 5 working days for the allegation of abuse which occurred on 5/17/23. Review on 5/30/23 of electronic communication between the Qualified Professional (QP) and FC #6's guardian/mother revealed: -Dated 5/18/23. -QP stated: "Good Morning, this is to notify you that [FC #6] was involved in a situation with staff. [FC #6] alleged that the staff 'smacked' him. [FC #6] does not have injuries and is safe. The staff has been removed and an investigation is being conducted. I will provide an update once the investigation is completed." Interview on 5/30/23 with FC #6 revealed: -He was staying with his family at home after recent discharge from the hospital. -Regarding incident at the facility with FS #8, reported that he had been upset in his room. -The Nurse and FS #8 were inside the room with him. No other staff or clients were in the room. -FS #8 pushed him against the wall, he started punching FS #8 and then FS #8 slapped him in the face. -FS #8 only slapped him once. Interview on 5/30/23 with FC #6's guardian/mother revealed: -She had received an email from the QP on 5/18/23 informing her that there had been an incident between her son and a staff at the facility and that the staff identified had been removed.	V 512		

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-Email did not identify the staff.
-Soon after, she received information that her son had been hospitalized and that he would be discharged from the facility.
-Her son was not going to be allowed back to the facility.
-She was informed that it was due to property damage created by her son.
-Her son was discharged from the hospital and staying with her at the home until placement for him was found.
-She did not know who was the staff that hit her son, but her son later told her that it was FS #8.
-FC #6 informed her that FS #8 had smacked him in the face.
-She had a lot of questions regarding how things were handled.
-She felt that staff were supposed to be trained. She felt that things should not have ended the way they did and should have been handled differently.

Interview on 6/2/23 with FS #8 revealed:
-Regarding incident with FC #6, "[FC #6] had not been taking his medications as he should have. He was irritated. He was being very aggressive to staff. He was being extra aggressive to the Nurse."
-He had a good rapport with FC #6.
-He placed himself between the Nurse and FC #6.
-FC #6 slapped him as he was in front of the Nurse.
-FC #6 calmed down, but then started to get angry again and physical.
-Another staff was called in to help and a restraint was made by the other staff.
-He had been doing this type of work for awhile.
-He knew how to work with the clients.
-It was a surprise to him that the allegation was

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brought out.
-FS #8 denied ever hitting FC #6.

Interviews on 5/31/23 with the QP revealed:
-She thought that an investigation about what happened between FS #8 and FC #6 was still ongoing.
-FS #8 had not returned to work since the incident occurred.
-The allegation was that FS #8 had slapped FC #6 in the face.
-FC #6 had to be involuntarily committed (IVC) the day after the incident.
-She was not able to talk to FC #6 about the incident because he was no longer at the facility.
-FC #6 had to be discharged due to excessive violent behavior and property damage. In a three day span, he had done significant damage to the property.
-She had phone conversations with FC #6's guardian/mother prior to the incident due to his behavior and the property damages.
-FC #6's guardian/mother had been updated with information. She was also sent pictures of the property destruction.

Interview on 5/31/23 with the Nurse revealed:
-Nurses were responsible for submitting IRIS reports.
-A lot of things had happened with FC #6.
-She acknowledged seeing FS #8 hitting FC #6.
-Incident occurred inside FC #6's bedroom.
-FC #6 was having a behavior and being aggressive towards her both physically and verbally.
-FS #8 stepped in and moved FC #6 against the wall.
-FC #6 hit FS#8 and that was when she observed FS #8 slap FC #6 in the face.
-An investigation was done about FC #6 being hit

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in the face by FS #8.
-Program Director completed the investigation.
-FC #6 had another behavior episode the next day and had to be IVC'd.
-FC #6 was discharged from the facility after he was hospitalized.

Interview on 5/31/23 with the Program Director revealed:
-On 5/17/23, she had been informed by the Nurse that former client #6 had said that FS #8 had hit him.
-She spoke with FC #6 and got his statement.
-FS #8 only spoke about what FC #6 was doing. Never admitted that he hit FC #6.
-Incident occurred in client's bedroom. There were no other witnesses besides the Nurse.
-Once she was informed of what had occurred, FC #8 was suspended.
-She completed the investigation of what occurred and recommended termination for FS #8.
-Investigation was sent to corporate compliance.
-She was waiting to hear from corporate regarding decision on FS #8 if to terminate him or provide training.

Interview on 5/31/23 with the Corporate Compliance Officer revealed:
-Investigation was still on-going.
-It had been hard to get statements from everyone.
-FS #8 had been suspended. Recommendation was for termination of employment. FS #8's termination date would be the day he was suspended (5/17/23.)
-FS #8 failed to follow de-escalation or let clinical staff intervene and should not have stepped in.
-She acknowledged the facility had not followed procedures in reporting the incident.

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V 512	Continued From page 32 -Facility did not report FS #8's name to Health Care Personnel Registry (HCPR) regarding the allegation of abuse made on 5/17/23. -Facility did not report to Disability Rights the allegation of abuse made on 5/17/23. -Facility did not report to Department of Social Services (DSS) the allegation of abuse made on 5/17/23. -Facility did not report their response to the allegation of abuse made on 5/17/23 to the Managed Entity/Managed Care Organization (LME/MCO). -Facility did not report to the LME/MCO the level III incident of allegation of abuse made on 5/17/23. Review on 6/9/23 of a Plan of Protection written by the Corporate Compliance Officer dated 6/9/23 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Canyon Hills Treatment Facility suspended immediately and eventually terminated the staff member who was accused of causing harm to client. Describe your plans to make sure the above happens. Canyon Hills Treatment Facility will implement the following standards to ensure no harm is caused to consumers: 1. All allegations will be investigated immediately and if staff is involved they will be suspended immediately pending an investigation. 2. IRIS reports, Disability Rights and all other regulatory agencies applicable will be notified as well as all guardians and care coordinates at the onset of the investigation." FC #6's diagnoses included: Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. FC #6 was 13 years old. On 5/17/23,	V 512		

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V 512	Continued From page 33 the nurse reported that FC #6 had been displaying property destruction, as well as physical and verbal aggression to others. At one point, FC #6 threatened the nurse and started walking towards her. FS #8 intervened and pushed FC #6 against the wall and slapped him the face. Facility staff failed to report the incident to the proper authorities (Disability Rights of North Carolina, local county Department of Social Services, Local Managed Entity/Managed Care Organization, Health Care Personal Registry.) In addition, there was no evidence of any other correction steps to ensure the safety of clients at the facility. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days. An administrative penalty of $1,500 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		