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 09/25/2023

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 September 25, 2023. The complaints were unsubstantiated (intake #NC206854, #NC207297, #NC00207587). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. This facility is licensed for 24 and currently was a census of 21, The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse.	V 315		

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V 315	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews, and interviews the facility failed to provide 24-hour onsite coverage by a registered nurse (RN.) The findings are: Review on 9/22/23 of CI #2's record revealed: -Age: 16 years old. -Admission date of 11/3/21. -Diagnoses of Attention Deficit Hyperactivity Disorder, Combined Type; Unspecified Anxiety Disorder; Unspecified Disruptive, Impulse Control; Conduct Disorder; Borderline Intellectual Functioning; Unspecified Depressive Disorder. Review on 9/22/23 of Former Client #3 (FC #3)'s record revealed: -Age: 14 years old. -Admission date of 10/18/22. -Diagnoses of Unspecified Trauma and Stressor Related Disorder; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder, Combined Type. Review on 9/25/23 of Staff #4's personnel record revealed: -He was hired on 2/27/23. -He was a Residential Advisor. Review on 9/25/23 of Staff #5's personnel record revealed: -He was hired on 11/21/22 -He was a Residential Advisor. Review of 9/25/23 of an In-house Investigation dated 9/5/23 revealed: -Type of Investigation: Complaint, Injury. -Statement from Staff #4: -Dated 9/5/23.	V 315		

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-"On Thursday 8/31/23 toward the ending of the evening recreational activities there were a couple of clients in the hallway horse playing. I encouraged them to stop but [FC #3] continued to be playful. [FC #3] and [Cl #2] started having a pushing match with [Cl #2]'s room door, I advised staff (who somewhat had a visual) that they were getting way out of hand and there was no nurse available..."

Interview on 9/25/23 with Staff #4 revealed:
-During the evening of 8/31/23, there had been an incident with two consumers (FC #3 and Cl #2). The consumers were horseplaying in the hallway. FC #3 went into Cl #2's room and started to fight.
-He alerted the other staff that it was getting out of hand.
-The nurse had just finished her shift and there were no other nurses working.
-It was unusual to not have a nurse on shift.
-The incident occurred about two hours after the nurse had left. The 2nd shift nurse left around 8:00 pm.
-There was no restraint made that evening. A nurse was not needed to deal with the incident between FC #3 and Cl #2.

Interview on 9/25/23 with Staff #5 revealed:
-When he was getting the kids ready to bed on 8/31/23, FC #3 started pushing his peer's room. He went into Cl #2's room and assaulted him.
-He never restrained FC #3. He did separate FC #3 from Cl #2 by pulling him away.
-FC #3 then went to attack him. He placed his arms out and FC #3 ran into them. FC #3 fell to the floor.
-FC #3 went to his room afterwards on his own.
-There was no nurse working that evening.
-"Nurse had gotten off work around 8 o'clock."

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V 315	Continued From page 3 -Incident occurred a little after she had left. Interview on 9/25/23 with the Corporate Compliance staff revealed: -On 8/31/23, the nurse had left at 8:00 pm. -There were no nurses from 8:00 pm to 8:00 am. -The nurse that was supposed to come to work at 8:00 pm on 8/31/23 had called in sick. -She was no longer employed by the agency. -Facility had a Nurse Lead that helped to find a replacement for whenever a nurse was out. -The Nurse Lead had not been informed on 8/31/23 that the nurse had called in sick. -This was highly unusual. Facility had nurses covering all shifts. Nurse Lead was always able to be called in. -She acknowledged that on 8/31/23, the facility had gone from 8:00 am to 8:00 pm without a nurse on duty.	V 315		
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 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	V 366		

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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
(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

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V 366	Continued From page 5 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 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.	V 366		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement written policies governing their responses to level I incidents. The findings are:

Review on 9/22/23 of CI #2's record revealed:
-Age: 16 years old.
-Admission date of 11/3/21.
-Diagnoses of Attention Deficit Hyperactivity Disorder, Combined Type; Unspecified Anxiety Disorder; Unspecified Disruptive, Impulse Control; Conduct Disorder; Borderline Intellectual Functioning; Unspecified Depressive Disorder.

Review on 9/22/23 of Former Client #3 (FC #3)'s record revealed:
-Age: 14 years old.
-Admission date of 10/18/22.
-Diagnoses of Unspecified Trauma and Stressor Related Disorder; Oppositional Defiant Disorder; Attention Deficit Hyperactivity Disorder, Combined Type.
-Behavior note dated 8/31/23:
-Note completed by Staff #5.
-"[FC #3 ran into his peer room and tried fighting him. When staff separated him from his peer and got him in his room, [FC #3] spat at staff and tried getting aggressive with staff.

Review on 9/25/23 of Staff #4's personnel record revealed:
-He was hired on 2/27/23.
-He was a Residential Advisor.

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Review on 9/25/23 of Staff #5's personnel record revealed:
-He was hired on 11/21/22
-He was a Residential Advisor.

Review of 9/25/23 of an In-house Investigation dated 9/5/23 revealed:
-Type of Investigation: Complaint, Injury.
-Detailed Narrative of How Incident Occurred:
-"Per report, on August 31, 2023, [FC #3] forced himself into another consumer's room and began fighting his peer. Staff separated the two consumers. [FC #3} then became physically and verbally aggressive towards staff. Staff assisted [FC #3] to his room. Per report, [FC #3] continued to be verbally aggressive by using profanity towards staff and then spit on staff and called staff [Staff #5] a "B****." Per staff report, [FC #3] then charged towards staff running aggressively. Staff [Staff #5] indicated that he placed both arms out in front of him, open handed to prevent [FC #3] from running into him over. Per report, [FC #3] then fell to the floor. [FC #3] then got up from the floor and then began breaking the shelf in his room. [FC #3] then took the broken wood pieces from the shelf and began inflicting self harm. Per report, the broken pieces were retrieved from his room. Staff continued to process with [FC #3] for some time and then [FC #3] went to bed."

Review on 9/22/23 of the facility's Incident Reports binder revealed:
-There was no report made for incident that occurred on 8/31/23 between FC #3 and CI #2.

Interview on 9/25/23 with CI #2 revealed:
-Regarding event on 8/31/23: "[FC #3] was trying to get into my room. He came in and punched me in my face. I punched him back."
-Staff #5 was trying to get FC #3 away from me.

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-FC #3 was never restrained.
-FC #3 went to his room.
-FC #3 also spat on Staff #5's face.

Interview on 9/25/23 with Staff #4 revealed:
-During the evening of 8/31/23, there had been an incident with two consumers (FC #3 and Cl #2). The consumers were horseplaying in the hallway. FC #3 went into Cl #2's room and started to fight.
-He alerted the other staff that it was getting out of hand.
-The nurse had just finished her shift and there were no other nurses working.
-It was unusual to not have a nurse on shift.
-The incident occurred about two hours after the nurse had left. The 2nd shift nurse left around 8:00 pm.
-There was no restraint made that evening. A nurse was not needed to deal with the incident between FC #3 and Cl #2.

Interview on 9/25/23 with Staff #5 revealed:
-When he was getting the kids ready to bed on 8/31/23, FC #3 started pushing his peer's room. He went into Cl #2's room and assaulted him.
-He never restrained FC #3. He did separate FC #3 from Cl #2 by pulling him away.
-FC #3 then went to attack him. He placed his arms out and FC #3 ran into them. FC #3 fell to the floor.
-FC #3 also spat on him.
-FC #3 went to his room afterwards on his own.
-There was no nurse working that evening.
-"Nurse had gotten off work around 8 o'clock."
-Incident occurred a little after she had left.

Interview on 9/25/23 with the Corporate Compliance staff revealed:
-On 8/31/23, the nurse had left at 8:00 pm.

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V 366	Continued From page 9 -There were no nurses from 8:00 pm to 8:00 am. -Incident between FC #3 and CI #2 occurred after the nurse had left. -She conducted investigation about what occurred that night. -She did not interview the staff, but rather read their written statements of what occurred. -She concluded that there had been a fight between FC #3 and CI #2. Staff acted properly to separate them. -It was a rollover effect. There was no incident report made because there were no nurses on duty when the incident occurred. -She acknowledged the facility failed to complete a written incident report for event that occurred on 8/31/23 between FC #3, CI #2 and Staff #5.	V 366		