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 07/03/2024

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 and follow up survey was completed on July 3, 2024. The complaints were substantiated (intake #NC00217820, NC00217833, NC00218050, NC00218149, NC00218288 and NC00218981). 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 has a current census of 21. The survey sample consisted of audits of 1 current client and 3 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 review and interviews, the facility failed to develop and implement adoption of standards that ensure operational and programmatic performance meeting applicable standards of practice. The findings are:

Review on 6/21/24 of the CFR §483.358(b)-Reporting of serious occurrences revealed:
-"The facility must report to both the State Medicaid agency and the Protection and Advocacy system no later than close of business the next business day after each serious occurrence...Staff must document that each serious occurrence was reported to both the state Medicaid agency and the state designated Protection and Advocacy system Disability Rights North Carolina (DRNC)..."

Review on 6/18/24 of a police report dated 12/15/23 revealed:
-"On 12/15/23 I was contacted by [the Program Director (PD)] of Canyon Hills. She stated another resident said that [Former Staff (FS) #11] assaulted him. I spoke with [FC #22] who stated that FS #11 pushed him then punched him in the stomach. [FC #22] also stated that [FS #11] grabbed him by his arm and bent his wrist for pain compliance. [FS #11] then walked him to his room where he let him go..."
-There was no documentation that indicated

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V 105	Continued From page 3 DRNC was informed about the above incident. -The facility failed to report a substantiated allegation of abuse to DRNC. Interviews on 6/19/24 and 6/25/24 with the PD revealed: -She was aware of the incident with FS #11 and FC #22. -Once the incident came to her attention FS #11 was suspended. -FS #11 was later terminated. -She recalled doing the investigation for that incident. -The allegation of abuse against FS #11 was substantiated. -"I knew some of the incidents were not reported to DRNC." -"If there was no incident report in IRIS, the incident was not reported to DRNC." -She confirmed the facility failed to report the incident to DRNC as required. -She confirmed the facility failed to report a substantiated allegation of abuse on 12/13/23 to DRNC.	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 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	V 132		

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V 132	Continued From page 4 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. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. The findings	V 132		

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V 132	Continued From page 5 are: Review on 6/18/24 of a police report dated 12/15/23 revealed: -"On 12/15/23 I was contacted by [the Program Director (PD)] of Canyon Hills. She stated another resident said that [Former Staff (FS) #11] assaulted him. I spoke with [Former Client (FC) #22] who stated that [FS #11] pushed him then punched him in the stomach. [FC #22] also stated that [FS #11] grabbed him by his arm and bent his wrist for pain compliance. [FS #11] then walked him to his room where he let him go..." Review on 6/25/24 of a HCPR 24-Hour Initial Report dated 12/15/23 revealed: -The facility reported an allegation of abuse against FS #11 related to FC #22. Review on 6/18/24 of in-house incident report dated 2/21/24 revealed: -"At approximately 2:26 pm [the Director of Nursing (DON)] sees [FC #24] in the hallway returning to the unit. [The DON] calls [FC #24] over to the nursing station. There were several bruises noticed to [FC #24's] left leg. [FC #24] is asked when he noticed the bruises [FC #24] states It happened the other day. [FC #24] is asked how many days ago was the other day [FC #24] states Two days ago. [FC #24] is asked how did he get bruised [FC #24] states I don't know probably when I was trying to squeeze under the chair to get away from staff..." Reviews on 6/18/24 and 6/25/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -On 6/21/24 the DON completed a report for an allegation of abuse that occurred on 5/12/24 with Former Client (FC #23) and Staff #1. The incident	V 132		

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V 132	Continued From page 6 was not reported to HCPR. -There were no level III incident reports submitted by the facility for the following allegations of abuse: 2/21/24-FC #24 alleged he was assaulted by FS #12; 12/11/23 FC #22 alleged he was assaulted by FS #11. Interview on 6/21/24 with the Corporate Compliance staff revealed: -The PD made her aware of the allegation of abuse against staff #1 on FC #23. -The PD made her aware of the abuse allegation on 6/20/24. -She was not aware on an allegation of abuse against FS #12 on FC #24. -The investigation was never completed for that allegation of abuse. -She was aware of the allegation of abuse against FS #11 on FC #22. -The investigation was completed for this abuse allegation. -She didn't report any of these allegations of abuse to HCPR. -The PD was responsible for reporting to HCPR. -She confirmed the agency failed to report the allegations of abuse to HCPR within five working days. Interviews on 6/19/24, 6/21/24 and 6/25/24 with the PD revealed: -They were doing the investigation for the allegation of abuse with FC #23 and staff #1 on 5/12/24. -They had not sent the 5 day report to HCPR for the 5/12/24 incident because they were waiting to hear from the Department of Social Services and the local police department. -The Social Worker for FC #24 brought it to her attention that FC #24 made an allegation against a staff.	V 132		

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V 132	Continued From page 7 -FC #24 said FS #12 pushed him and he bruised his leg. -They did an investigation for that incident in February 2024 (no specific date). -She "thought" that incident was reported to HCPR. -She was aware of the incident with FC #22 being assaulted by FS #11 in December 2023 (12/11/23). -She was not sure if that incident was reported to HCPR. -"Sometimes it is confusing when we are supposed to contact HCPR if there is an allegation of abuse." -She "rarely" reports to HCPR. -The Corporate Compliance staff was responsible for reporting allegations of abuse to HCPR. -She would only report to HCPR if the Corporate Compliance staff was not available. -She confirmed the agency failed to report the allegations of abuse to HCPR within five working days.	V 132		
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	V 315		

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V 315	Continued From page 8 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. This Rule is not met as evidenced by: Based on observation, record review and interviews the facility failed to ensure at least two direct care staff members were present with every six children or adolescents in each residential unit. The findings are: Observation on 6/19/24 at approximately 8:50 am revealed: -The posted speed limit for the two lane highway near the facility was 55 miles per hour. Review on 6/20/24 of the Work Schedule for May 2024 revealed: -Unit A had three staff scheduled for 1st shift (the Facility Manager, staff #1 and staff #4) on 5/12/24. -Unit B had three staff scheduled (staff #2, staff #5 and Former Staff (FS) #10) on 5/12/24. Review on 6/19/24 of the client list revealed: -There were eleven clients on unit A on May 12, 2024. -There were eight clients on unit B on May 12, 2024. Review on 6/18/24 of an in-house incident report dated 5/12/24 revealed: -"At approximately 1:15 pm, [Registered Nurse	V 315		

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V 315	Continued From page 9 (RN) #1] was notified by [Staff #2] that [Former Client (FC) #23] ran out the side door and then climbed over the fence. At this time, [RN #1] ran out the front door along with staff and noted [FC #23] running through the field towards traffic. [RN #1] called and informed upper management and then was informed to call 911, which informed notified city police. While awaiting city police, staff along with [RN #1] was able to safely reach up to [FC #23] and escort him safely back to facility ... [FC #23] has notable superficial scratches on his upper extremities, [FC #23] stated he think he got this when he was running in high weeds ..." Attempts on 6/19/24 and 6/21/24 to interview FC #23 revealed: -FC #23's guardian was contacted via telephone and did not answer. -A voicemail message was left for FC #23's guardian requesting the phone call be returned. -The phone call was never returned by FC #23's guardian prior to the exit on 7/3/24. Interview on 6/20/24 with client #3 revealed: -He knew about the incident in May 2024 (5/12/24) with FC #23 leaving the facility. -There were two staff on unit A the day of the incident. -Staff #1 and Staff #4 were the two staff working on unit A that day. -"There were about 8 clients on the unit." -"Staff opened the doors to units A and B and walked back and forth so they could watch us." Interview on 6/20/24 with client #4 revealed: -He knew about the incident with FC #23 leaving the facility in May 2024 (5/12/24). -There were two staff on unit A the day of the incident. -Staff #1 and staff #4 were the two staff.	V 315		

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V 315	Continued From page 10 -He couldn't remember how many clients were on his unit the day of the incident. Interview on 6/20/24 with client #5 revealed: -He knew about the incident with FC #23 when he left the facility in May 2024 (5/12/24) . -There were only two staff on unit A that day. -Staff #1 and staff #4 were the only two staff on unit A with them. Interview on 6/20/24 with client #7 revealed: -He was aware of the incident on 5/12/24 when FC #23 left the facility. -There were two staff on unit A the day of the incident. -The staff working were staff #1 and staff #4. -"[Staff #1] was on the unit initially and had to leave to help find [FC #23]." Interview on 6/20/24 with client #10 revealed: -He recalled the incident with FC #23 leaving the facility on 5/12/24. -FC #23 went out the backdoor of the facility and climbed over the fence. -There were two female staff on the unit B during that incident. -There was a third staff person on unit B, however that staff went to the other unit. -Staff on the unit that day were staff #2, staff #4 and he could not remember the other female staff's name. Interview on 6/20/24 with client #11 revealed: -He recalled the incident with FC #23 on 5/12/24 when he left the facility. -He saw FC #23 because he was looking out the window. -He saw FC #23 leave the facility. -FC #23 ran out the back door and jumped over the fence.	V 315		

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V 315	Continued From page 11 -He saw FC #23 jump and pull himself up over the fence. -FC #23 took off and ran in the field near the highway. -Prior to FC #23 leaving the facility there were two female staff on the unit. -Staff #4 and another female staff were towards the other end of the hallway. -FC #23 was on the opposite end on the hallway near the exit door. -Staff #2 was also working on Unit B but had gone to the other unit. -FC #23 left shortly after staff #2 left unit B and went over to unit A. Interview on 6/20/24 with client #12 revealed: -He knew about the incident with FC #23 from May 2024 (5/12/24). -FC #23's bedroom was across the hallway from his bedroom. -"I saw [FC #23] go out the back door and scale the fence." -"I thought there two female staff working on the unit B with them during that incident." -The female staff were at the opposite end of the hallway. -"By the time one of the female staff ran down the hallway [FC #23] had already went out the door and scaled the fence." -He saw FC #23 pull himself up and go over the fence. Interview on 6/20/24 with client #13 revealed: -He moved to unit B after the incident with FC #23 in May 2024 (5/12/24). -He was on unit A the day of the incident. -He didn't see FC #23 when he left the building. -There were only 2 staff working on unit A the day of the incident. -The staff on unit A were staff #1 and staff #4.	V 315		

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V 315	Continued From page 12 Interview on 6/19/24 with staff #1 revealed: -He recalled the incident with FC #23 on 5/12/24. -FC #23 was on unit B. -He worked on unit A the day of the incident. -He was working on unit A with staff #4. -There were 3 staff working on unit B. -Those staff were staff #2, staff #5 and FS #10. -He heard it over the "walkie talkie" that FC #23 ran away from the facility. -He left the facility and started running down the highway behind FC #23. -Staff #2 also left the facility to follow FS #23. -Staff #2 was already running ahead of him (staff #1). -They were both running behind FC #23 near the highway. Interview on 6/19/24 with staff #2 revealed: -He recalled the incident with FC #23 on 5/12/24. -He worked on unit B the day of the incident.. -They were "a little short staffed" that day. -He walked to unit A that day "to help with a situation with a client." -A few minutes later he heard a call that a client left the facility. -He heard the call over the radio when he was on unit B. -He ran outside and saw FC #23 running through the field in front of the facility near the highway. -He started chasing behind FC #23. -He also saw staff #1 chasing behind FC #23. -"I sort of figured it was [FC #23] because he was supposed to be supervised by staff." -FC #23 was supposed to be supervised on the unit. -"I am not sure if staff were supervising [FC #23] properly when I left the unit." -Staff #5 and FS #10 were the two staff left on unit B when he went over to unit A.	V 315		

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V 315	Continued From page 13 -Staff #1 and staff #4 were the two staff on unit A. -There was not a third staff on unit A the day of the incident on 5/12/24. -There were 7-8 clients on unit B the day of the incident. -He "thought" unit A had at least 10 or more clients. -"I assumed [FC #23] went out the side door near his bedroom." -"I assumed" [FC #23] went around to the fence and stood on top of the AC unit and jumped over the fence." -The Facility Manager showed up after they returned to the facility with FC #23. -The Facility Manager was not at the facility prior to the incident. -The Facility Manager was not working on the unit with them. Interview on 6/20/24 with staff #5 revealed: -She worked on unit B the day of the incident with FC #23 when he left the facility in May 2024 (5/12/24). -FS #10 and staff #2 were also working on unit B with her. -Staff #2 left unit B because he had to "deal" with an incident on unit A. -When staff #2 left unit B it was her and FS #10 on the unit. -FC #23 was upset the day of the incident. -FC #23 was "fussing and cussing." -She was sitting in a chair at the end of the hallway doing her notes. -FC #23 was on the same hallway, however his bedroom was at the opposite end of the hallway. -She heard the exit door alarm go off. -FC #23 ran out the exit door near his bedroom. -FC #23 "bolted" out the exit door. -FS #10 was also on the hallway standing near her and had just turned to walk away.	V 315		

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V 315	Continued From page 14 -She called the emergency code to call for help. -FS #10 ran toward the other end of the hallway, however FS #23 had already jumped the fence. -Staff #1 and staff #2 left on units A and B and went to look for FC #23. -They were "short staff that day." -Unit A had two staff, staff #4 and staff #1. -The Facility Manager was not in the building prior to that incident. -She "thought" the Facility Manager arrived to the facility once FC #23 returned to the facility. Interview on 6/20/24 with FS #10 revealed: -She was working on unit B on 5/12/24 when FC #23 left the facility. -Staff #5 was also on unit B during that incident. -She couldn't remember if there were any other staff on unit B with them. -FC #23 ran out the back door near his bedroom and jumped over the fence. -She was on the hallway, however she was standing towards the other end of the hallway. -She started running towards the back door when FC #23 opened it. -She could not catch FC #23. -FC #23 had already jumped over the fence by the time she caught up to him. Interview on 6/18/24 with the Facility Manager revealed: -FC #23 ran away from the facility in May 2024 (5/12/24). -FC #23 ran out the door on the hallway near his bedroom. -He was told FC #23 jumped the fence outside and ran down the street. -Staff #1 and staff #2 followed behind FC #23. -The incident happened on the weekend and he was not working that day. -Staff called about the incident and he came to	V 315		

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V 315	Continued From page 15 the facility later that afternoon. Interview on 6/19/24 with the Program Director revealed: -She was aware of the incident on 5/12/24 with FC #23 leaving facility. -She had no explanation as to why the facility was not at minimum staff coverage. -She confirmed the facility failed to meet minimum staffing requirements. Review on 6/25/24 of a Plan of Protection written by the Program Director dated 6/25/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Canyon Hills Treatment Facility will ensure that the facility will maintain adequate staffing as required by rule. Describe your plans to make sure the above happens. Canyon Hills will create an employee schedule that meets the requirement of 2 staff per 6 consumers. Canyon Hills will create a back up staff in the absences of scheduled staff members." Clients diagnoses included Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Adjustment Disorder, Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. On 5/12/24 FC #23 eloped from the facility, jumping over the facility fence and leaving the facility grounds. There were two staff working on unit A and three staff working on unit B the day of the incident. There were eleven clients on unit A and eight clients on unit B. Staff #1 and staff #2 left the facility to follow FC #23 when he left the facility. Three staff remained in the building with eighteen clients. The facility was below the minimum staff coverage. This deficiency constitutes a Type B rule violation	V 315		

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V 315	Continued From page 16 which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 315		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to notify Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of allegations of abuse affecting one of three audited current staff (#1). The findings are: Review on 6/18/24 of staff #1's personnel record revealed: -Date of hire was 10/6/23. -Hired as a Residential Advisor. Review on 6/18/24 of former client (FC) #23's	V 318		

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record revealed:
-Admission date of 4/22/24.
-Diagnoses of Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder.
-He was 16 years old.
-He was discharged on 5/12/24.

Review on 6/18/24 of in-house incident report dated 5/12/24 revealed:
-"At approximately 1:15 pm, [Registered Nurse (RN) #1] was notified by [Staff #2] that [FC #23] ran out the side door and then climbed over the fence. At this time, [RN #1] ran out the front door along with staff and noted [FC #23] running through the field towards traffic. [RN #1] called and informed upper management and then was informed to call 911, which informed notified city police. While awaiting city police, staff along with [RN #1] was able to safely reach up to [FC #23] and escort him safely back to facility ...[FC #23] has notable superficial scratches on his upper extremities, [FC #23] stated he think he got this when he was running in high weeds ..."

Review on 6/18/24 of a police report dated 5/12/24 revealed:
-"On 5/12/24 at 1326 (1:26 pm) hrs (hours), [Police Officer's Name] responded to [Name of Road] in reference to a runway juvenile from Canyon Hill Treatment Center. While responding [Name of County] Dispatch advised they were receiving multiple calls into 911 in reference to a person being assaulted. [Name of County] Dispatch also advised the treatment center had called and stated they had the juvenile and need us to meet them at the facility...Upon arriving at the facility I saw their van parked out front with a broken window. Employees on scene advised the juvenile [FC #23] had broken the window. I made contact with [FC #23] who stated he was

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V 318	Continued From page 18 assaulted by [Staff #1] who was one of two employee who went to go after [FC #23]. The other employee was [Staff #2]. [FC #23] stated he was being hit in the lower area of his back with a fist by [Staff #1]...[FC #23] did state he picked up a rock and threw it over their head all while picking up another rock. [FC #23] stated he was tackled to the ground which is when [Staff #1] started punching him. [FC #23] had multiple scrapes all over his body, the area he was claiming to have been hit by [Staff #1] was red a had some swelling...I made contact with [Name of County] Dispatch and gathered the three numbers for the persons calling 911. The First person I talked with was [community witness #1], stated he saw [FC #23] running across the field and though may he was just running. [Community witness #1] then stated he saw two men get out of a vehicle and run towards [FC #23]. [Community witness #1] then stated they went to the ground with [FC #23] and also stated one of the males wearing a white shirt and a red hat was punching [FC #23] with what appeared to be a closed fist. The second person I spoke with was [community witness #2] who stated saw two men throw a person to the ground. [Community witness #2] stated she saw one of the males appeared to hit the other with a closed fist. The third I spoke with was [community witness #3] who stated all he saw two men tackling another person." -Staff #1 was listed as the suspect and it was also noted staff #1 was wearing a white shirt and red hat. Review on 6/21/24 of the North Carolina Incident Response Improvement System (IRIS) revealed: -HCPR was not informed of the allegation of abuse within 24 hours.	V 318		

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V 318	Continued From page 19 Interview on 6/19/24 with the Program Director (PD) revealed: -She was aware of the incident on 5/12/24 with FC #23 leaving facility. -It was never reported that anyone saw staff #1 assault FC #23 when he left the facility on 5/12/24. Interviews on 6/21/24 and 6/25/24 with the PD revealed: -They were doing the investigation for the allegation of abuse with FC #23 and staff #1 from 5/12/24. -She did not do the 24-hour report for HCPR. -"Sometimes it is confusing when we are supposed to contact HCPR if there is an allegation of abuse." -She "rarely" reports to HCPR. -The Corporate Compliance staff was responsible for reporting to HCPR. -She would only report to HCPR if the Corporate Compliance staff was not available. -She confirmed the facility failed to notify Health Care Personnel Registry (HCPR) within 24 hours of learning about all allegations of abuse.	V 318		
V 366	27G .0603 Incident Response Requirements 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	V 366		

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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
(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

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V 366	Continued From page 21 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 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;	V 366		

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V 366	Continued From page 22 (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 policy governing their response to Level II and III incidents as required. The findings are: Review on 6/18/24 of an in-house incident reports revealed: -5/12/24-"At approximately 1:15 pm, [Registered Nurse (RN) #1] was notified by [Staff #2] that [Former Client (FC) #23] ran out the side door and then climbed over the fence. At this time, [RN #1] ran out the front door along with staff and noted [FC #23] running through the field towards traffic. [RN #1] called and informed upper management and then was informed to call 911, which informed notified city police. While awaiting city police, staff along with [RN #1] was able to safely reach up to [FC #23] and escort him safely back to facility ...[FC #23] has notable superficial scratches on his upper extremities, [FC #23] stated he think he got this when he was running in high weeds ..." -2/21/24-"At approximately 2:26 pm [the Director of Nursing (DON)] sees [FC #24] in the hallway returning to the unit. [The DON] calls [FC #24] over to the nursing station. There were several bruises noticed to [FC #24's] left leg. [FC #24] is asked when he noticed the bruises [FC #24]	V 366		

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V 366	Continued From page 23 states It happened the other day. [FC #24] is asked how many days ago was the other day [FC #24] states Two days ago. [FC #24] is asked how did he get bruised [FC #24] states I don't know probably when I was trying to squeeze under the chair to get away from staff..." Review on 6/18/24 of a police report dated 12/15/23 revealed: -"On 12/15/23 I was contacted by [the Program Director (PD)] of Canyon Hills. She stated another resident said that [Former Staff (FS) #11] assaulted him. I spoke with [FC #22] who stated that FS #11 pushed him then punched him in the stomach. [FC #22] also stated that [FS #11] grabbed him by his arm and bent his wrist for pain compliance. [FS #11] then walked him to his room where he let him go..." Review on 5/28/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There was no level II incident report submitted by the facility for the incident on 5/12/24. -There were no Level III incident reports submitted by facility for the incidents on 12/13/23 and 2/21/24. -There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 6/19/24 with the DON revealed: -Nursing staff were responsible for completing incident reports.	V 366		

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V 366	Continued From page 24 -The nurse on duty was responsible for the incident report and putting the incident report in IRIS if necessary. -She had no explanation as to why some of the incidents were not put into IRIS. -She confirmed the facility failed to implement a policy governing their response to Level II and Level III incidents as required. Interview on 6/21/24 with the Corporate Compliance staff revealed: -Nursing staff were responsible for putting incident reports into IRIS. -The DON was supposed to ensure the incident was completed by the nurse on duty. -As the Corporate Compliance staff she was also supposed to make sure the IRIS report was done if an incident was brought to her attention. -"There is a system in place. We didn't follow our system for some of these incidents." -She confirmed the facility failed to implement a policy governing their response to Level II and Level III incidents as required. Interview on 6/19/24 with the PD revealed: -She didn't put incident reports into IRIS. -Nursing staff were responsible for putting incident reports into IRIS. -She wasn't sure why these incidents were not in IRIS. -She confirmed the facility failed to implement a policy governing their response to Level II and Level III incidents as required.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 367		

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V 367	Continued From page 25 (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 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	V 367		

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(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 367	Continued From page 26 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 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.	V 367		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are:

Review on 6/18/24 of an in-house incident reports revealed:
-5/12/24-"At approximately 1:15 pm, [Registered Nurse (RN) #1] was notified by [Staff #2] that [Former Client (FC) #23] ran out the side door and then climbed over the fence. At this time, [RN #1] ran out the front door along with staff and noted [FC #23] running through the field towards traffic. [RN #1] called and informed upper management and then was informed to call 911, which informed notified city police. While awaiting city police, staff along with [RN #1] was able to safely reach up to [FC #23] and escort him safely back to facility ...[FC #23] has notable superficial scratches on his upper extremities, [FC #23] stated he think he got this when he was running in high weeds ..."
-2/21/24-"At approximately 2:26 pm [the Director of Nursing (DON)] sees [FC #24] in the hallway returning to the unit. [The DON] calls [FC #24] over to the nursing station. There were several bruises noticed to [FC #24's] left leg. [FC #24] is asked when he noticed the bruises [FC #24] states It happened the other day. [FC #24] is asked how many days ago was the other day [FC #24] states Two days ago. [FC #24] is asked how

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did he get bruised [FC #24] states I don't know probably when I was trying to squeeze under the chair to get away from staff..."

Review on 6/18/24 of a police report dated 12/15/23 revealed:
-"On 12/15/23 I was contacted by [the Program Director (PD)] of Canyon Hills. She stated another resident said that [Former Staff (FS) #11] assaulted him. I spoke with [FC #22] who stated that FS #11 pushed him then punched him in the stomach. [FC #22] also stated that [FS #11] grabbed him by his arm and bent his wrist for pain compliance. [FS #11] then walked him to his room where he let him go..."

Review on 5/28/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed:
-There was no level II incident report submitted by the facility for the incident on 5/12/24.
-There were no Level III incident reports submitted by facility for the incidents on 12/13/23 and 2/21/24.

Interview on 6/19/24 with the DON revealed:
-Nursing staff were responsible for completing incident reports.
-The nurse on duty was responsible for the incident report and putting the incident report in IRIS if necessary.
-She had no explanation as to why some of the incidents were not put into IRIS.
-She confirmed the facility failed to report the above incident to LME/MCO within 72 hours.

Interview on 6/21/24 with the Corporate Compliance staff revealed:
-Nursing staff were responsible for putting incident reports into IRIS.

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V 367	Continued From page 29 -The DON was supposed to ensure the incident was completed by the nurse on duty. -As the Corporate Compliance staff she was also supposed to make sure the IRIS report was done if an incident was brought to her attention. -"There is a system in place. We didn't follow our system for some of these incidents." -She confirmed the facility failed to report the above incident to LME/MCO within 72 hours. Interview on 6/19/24 with the PD revealed: -She didn't put incident reports into IRIS. -Nursing staff were responsible for putting incident reports into IRIS. -She wasn't sure why these incidents were not in IRIS. -She confirmed the facility failed to report the above incident to LME/MCO within 72 hours.	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: (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.	V 500		

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V 500	Continued From page 30 (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 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	V 500		

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V 500	Continued From page 31 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: Review on 6/18/24 of a police report dated 12/15/23 revealed: -"On 12/15/23 I was contacted by [the Program Director (PD)] of Canyon Hills. She stated another resident said that [Former Staff (FS) #11] assaulted him. I spoke with [Former Client (FC #22)] who stated that FS #11 pushed him then punched him in the stomach. [FC #22] also stated that [FS #11] grabbed him by his arm and bent his wrist for pain compliance. [FS #11] then walked him to his room where he let him go..." Review on 6/25/24 of a HCPR 24-Hour Initial Report dated 12/15/23 revealed: -The facility reported an allegation of abuse against FS #11 related to FC #22. Review on 6/18/24 of in-house incident report dated 2/21/24 revealed: -"At approximately 2:26 pm [the Director of Nursing] sees [FC #24] in the hallway returning to the unit. [The Director of Nursing] calls [FC #24] over to the nursing station. There were several bruises noticed to [FC #24's] left leg. [FC #24] is asked when he noticed the bruises [FC #24] states It happened the other day. [FC #24] is asked how many days ago was the other day [FC #24] states Two days ago. [FC #24] is asked how did he get bruised [FC #24] states I don't know	V 500		

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probably when I was trying to squeeze under the chair to get away from staff..."

Reviews on 6/18/24 and 6/25/24 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-There were no level III incident reports submitted by the facility for the following allegations of abuse: 2/21/24-FC #24 alleged he was assaulted by FS #12; 12/11/23 FC #22 alleged he was assaulted by FS #11.

Interview on 6/21/24 with the Corporate Compliance staff revealed:
-She was not aware on an allegation of abuse against FS #12 on FC #24.
-The investigation was never completed for that allegation of abuse.
-She was aware of the allegation of abuse against FS #11 on FC #22.
-The investigation was completed for this abuse allegation.
-She didn't report any of these allegations of abuse to DSS.
-The Program Director was responsible for reporting to DSS.
-She confirmed the agency failed to report the above allegations of abuse to DSS.

Interviews on 6/19/24, 6/21/24 and 6/25/24 with the PD revealed:
-The Social Worker for FC #24 brought it to her attention that FC #24 made an allegation against a staff.
-FC #24 said FS #12 pushed him and he bruised his leg.
-They did an investigation for that incident in February 2024 (no specific date).
-She "thought" that incident was reported to DSS.
-She was aware of the incident with FC #22 being

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V 500	Continued From page 33 assaulted by FS #11 in December 2023 (12/11/23). -She was not sure if that incident was reported to DSS. -"Sometimes it is confusing when we are supposed to contact DSS if there is an allegation of abuse." -She "rarely" reports to DSS. -The Corporate Compliance staff was responsible for reporting allegations of abuse to DSS. -She would only report to DSS if the Corporate Compliance staff was not available. -She confirmed the agency failed to report the above allegations of abuse to DSS.	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 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	V 512		

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V 512	Continued From page 34 (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, one of four audited current staff (#1) abused one of three audited former clients (FC #23) and one of three audited former staff (FS #11) abused one of three audited former clients (FC #22). The findings are: 1. Observation on 6/19/24 at approximately 8:50 am revealed: -The posted speed limit for the two lane highway near the facility was 55 miles per hour. Review on 6/18/24 of staff #1's personnel record revealed: -Date of hire was 10/6/23. -Hired as a Residential Advisor. Review on 6/18/24 of FC #23's record revealed: -Admission date of 4/22/24. -Diagnoses of Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. -He was 16 years old. -He was discharged on 5/12/24. Review on 6/18/24 of an in-house incident report dated 5/12/24 revealed: -"At approximately 1:15 pm, [Registered Nurse (RN) #1] was notified by [Staff #2] that [FC #23] ran out the side door and then climbed over the fence. At this time, [RN #1] ran out the front door along with staff and noted [FC #23] running through the field towards traffic. [RN #1] called and informed upper management and then was	V 512		

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informed to call 911, which informed notified city police. While awaiting city police, staff along with [RN #1] was able to safely reach up to [FC #23] and escort him safely back to facility ...[FC #23] has notable superficial scratches on his upper extremities, [FC #23] stated he think he got this when he was running in high weeds ..."

Review on 6/18/24 of a police report dated 5/12/24 revealed:
-"On 5/12/24 at 1326 (1:26 pm) hrs (hours), [Police Officer's Name] responded to [Name of Road] in reference to a runway juvenile from Canyon Hill Treatment Center. While responding [Name of County] Dispatch advised they were receiving multiple calls into 911 in reference to a person being assaulted. [Name of County] Dispatch also advised the treatment center had called and stated they had the juvenile and need us to meet them at the facility...Upon arriving at the facility I saw their van parked out front with a broken window. Employees on scene advised the juvenile [FC #23] had broken the window. I made contact with [FC #23] who stated he was assaulted by [Staff #1] who was one of two employee who went to go after [FC #23]. The other employee was [Staff #2]. [FC #23] stated he was being hit in the lower area of his back with a fist by [Staff #1]...[FC #23] did state he picked up a rock and threw it over their head all while picking up another rock. [FC #23] stated he was tackled to the ground which is when [Staff #1] started punching him. [FC #23] had multiple scrapes all over his body, the area he was claiming to have been hit by [Staff #1] was red a had some swelling...I made contact with [Name of County] Dispatch and gathered the three numbers for the persons calling 911. The First person I talked with was [community witness #1], stated he saw [FC #23] running across the field

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V 512	Continued From page 36 and though may he was just running. [Community witness #1] then stated he saw two men get out of a vehicle and run towards [FC #23]. [Community witness #1] then stated they went to the ground with [FC #23] and also stated one of the males wearing a white shirt and a red hat was punching [FC #23] with what appeared to be a closed fist. The second person I spoke with was [community witness #2] who stated saw two men throw a person to the ground. [Community witness #2] stated she saw one of the males appeared to hit the other with a closed fist. The third I spoke with was [community witness #3] who stated all he saw two men tackling another person." -Staff #1 was listed as the suspect and it was also noted staff #1 was wearing a white shirt and red hat. Attempts on 6/19/24 and 6/21/24 to interview FC #23 revealed: -FC #23's guardian was contacted via telephone and did not answer. -A voicemail message was left for FC #23's guardian requesting the phone call be returned. -The phone call was never returned by FC #23's guardian prior to the exit on 7/3/24. Interview on 6/20/24 with client #11 revealed: -He recalled the incident with FC #23 on 5/12/24 when he left the facility. -He saw FC #23 because he was looking out the window. -He saw FC #23 leave the facility. -FC #23 ran out the back door and jumped over the fence. -He saw FC #23 jump and pull himself up over the fence. -FC #23 took off and ran in the field near the highway.	V 512		

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V 512	Continued From page 37 -Staff #1 and staff #2 brought FC #23 back to the facility. -When FC #23 returned to the facility he said he was hit in the ribs by one of the staff. -FC #23 did not specify which staff. -He saw a few scratches on FC #23's stomach because FC #23's shirt was ripped. Interview on 6/20/24 with client #12 revealed: -He knew about the incident with FC #23 from May 2024 (5/12/24). -FC #23's bedroom was across the hallway from his bedroom. -"I saw [FC #23] go out the back door and scale the fence." -When FC #23 returned to the facility, FC #23 said "somebody hit him." -FC #23 would not say who hit him. Interview on 6/19/24 with staff #1 revealed: -He recalled the incident with FC #23 on 5/12/24. -FC #23 was on unit B. -He worked on unit A the day of the incident. -He heard it over the "walkie talkie" that FC #23 ran away from the facility. -He left the facility and started running down the highway behind FC #23. -Staff #2 also left the facility to follow FS #23. -Staff #2 was already running ahead of him (staff #1). -They were both running behind FC #23 near the highway. -Nurse #1 also left the facility with them. -Nurse #1 drove her Sports Utility Vehicle (SUV) and followed behind FC #23. -They caught up to FC #23 by the middle school on a dirt road across from a gas station. -FC #23 started throwing rocks at them. -Nurse #1 told FC #23 to get in the SUV and FC #23 refused to get into her vehicle.	V 512		

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V 512	Continued From page 38 -They were able to convince FC #23 to stop throwing rocks. -They got close to FC #23 and walked him to the SUV. -Staff #2 was on one side of FC #23 and was holding one of FC #23's arms. -Staff #1 was on the other side of FC #23 and was holding the other arm. -They walked FC #23 to the SUV and he got into the back seat. -"[FC #23] got into the SUV of his free will, we did not force him into the vehicle." Interview on 6/19/24 with staff #2 revealed: -He recalled the incident with FC #23 on 5/12/24. -He worked on unit B the day of the incident.. -He walked to unit A that day "to help with a situation with a client." -He heard a call over the radio that a client left the facility when he was on unit B. -He ran outside and saw FC #23 running through the field in front of the facility near the highway. -He started chasing behind FC #23. -He also saw staff #1 chasing behind FC #23. -Nurse #1 was also following them in a SUV. -When they got close to FC #23, he started throwing rocks at them. -Staff #1 then got into someone's car. -The person was not a staff, but he thought it was someone staff #1 knew. -That person drove staff #1 further down the road. -There was a housing development near the convenience store. -They caught up with FC #23 near that housing development. -Staff #1 got out of the car and FC #23 ran the opposite way. -Staff #2 tried to grab FC #23 and FC #23 also got away from him.	V 512		

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V 512	Continued From page 39 -Staff #1 then grabbed FC #23 from behind by his shoulders. -Staff #1 and FC #23 both fell on the ground. -They both grabbed FC #23 by the arm and stood him up off of the ground. -Nurse #1 pulled over and they walked FC #23 to the SUV. -They then returned to the facility. Interview on 7/1/24 with RN #1 revealed: -She recalled incident with FC #23 when he left the facility on 5/12/24. -She was notified FC #23 left the facility and jumped the fence. -She jumped into her SUV and followed FC #23 as he ran along the highway. -She asked FC #23 to get into the SUV. -She made it to FC #23 before staff #2 and staff #1 because she was driving her SUV. -Staff #2 and staff #1 caught up to FC #23 a few minutes later. -FC #23 was ran and walked along the highway. -FC #23 would start walking to catch his breath and then start running again. -FC #23 was also throwing rocks at staff #1 and staff #2. -She had a good relationship with FC #23 and she convinced him to stop throwing the rocks. -She talked to FC #23 and he then got into the SUV. -Staff #1 and staff #2 also got into the SUV and rode back with them to the facility. -"[FC #23] got into the vehicle willingly." -She was glad FC #23 got into the vehicle "because traffic was so bad on that road." Interview on 6/18/24 with a local police department detective revealed: -They received a call on 5/12/24 from Canyon Hills that FC #23 ran away from the facility.	V 512		

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V 512	Continued From page 40 -The police dispatch person also received several calls while the police officer was responding to the incident. -"It was reported that a person was being assaulted in the same area [FC #23] was reported to have possibly walked to when he left the facility." -At least three people called about witnessing an assault on someone in the community. -"These 3 people in the community actually witnessed facility staff assaulting [FC #23] near the [Name of store] not far from the facility." -Community witness #1 said "he saw a male staff punch [FC #23] with a closed fist." -Community witness #1 did not specify where FC #23 was punched. -Community witness #2 said she saw "a male staff throw [FC #23] on the ground and one of the male staff hit [FC #23] in face with a closed fist." -Community witness #3 said "he saw a male staff tackle [FC #23]." -One of the community witnesses was able to describe to the police officer the clothing that was being worn by one of the staff during that incident. -By the time the police officer responded the facility staff had already taken FC #23 back to the facility. -While the police officer was at the facility FC #23 said staff #1 assaulted him. -FC #23 told the police officer staff #1 punched him several times in his side. Interview on 6/18/24 with community witness #1 revealed: -Towards the middle of May 2024 (5/12/24) he witnessed an incident while he was in his driveway. -He lived near the convenience store. -He saw a tall skinny teenage male running down the road.	V 512		

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V 512	Continued From page 41	V 512		

-"I thought to myself this guy must be training for something."
-A little later he saw a SUV that appeared to be following the teenage male.
-"This actually caught my attention."
-He told his wife and kids to go back into the house.
-He then saw the teenage male running down the street near his home.
-He saw the SUV again and an adult male pulled the SUV to the side of the road.
-Another adult male jumped out of the passenger side door of the SUV.
-"The adult male tackled the teenager and took him down to the ground."
-Another vehicle then pulled up and another adult male got out of that vehicle.
-"I called 911 because I thought the teenager was being kidnapped initially."
-He saw one of the adult males down on the ground crouching over the teenager.
-"The adult male pulled back his arm and punched the teenager in the rib area 2 times."
-The teenager was laying face down on his stomach.
-"The 1st adult male had one of his knees on the teenager holding him down."
-He couldn't remember where the adult male's knee was located on the teenager.
-"The 2nd adult male appeared to help restrain the teenager when he got out of his vehicle."
-"The 2nd adult male was helping to hold the teenager down on the ground."
-He never saw the 2nd adult male punch the teenager.
-He then saw the 1st adult male pick the teenager up off the ground and walk him over to the SUV.
-"The 1st adult male slammed the teenager into the door of the SUV."
-"The 1st adult male then shoved the teenager

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V 512	Continued From page 42 into the back seat of the SUV and they left the area." Interview on 6/18/24 with community witness #2 revealed: -She witnessed an incident in May 2024 (5/12/24) near the convenience store near the local highway. -She was headed home from work and saw "three adult males attacking a young boy on the side of the road." -"I thought they were robbing this boy or trying to beat him up." -"All three of the adult males were holding this boy down on the ground." -There was an adult male on the boy's right side. -There was also an adult male on the boys left side and an adult male near the top of the boy's head. -"One of the adult males punched the boy in his side several times." -The adult males were in a car and SUV during that incident. -The adult males picked the boy up from the ground. -She pulled over and decided to call 911 to report the incident. -She was looking down at her phone and didn't see the adult males and boy when they left the area. An attempt on 6/18/24 to interview community witness #3 revealed: -He answered the telephone and stated he was at work and could not talk. -He stated he would return the call whenever he got a break. -He never returned the phone call by close of survey on 7/3/24.	V 512		

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V 512	Continued From page 43 Interview on 6/19/24 with the Program Director (PD) revealed: -She was aware of the incident on 5/12/24 with FC #23 leaving facility. -She came to the facility that evening after the incident occurred because she was out of town earlier that day. -FC #23 was at the facility and would not talk with her. -No one reported witnessing anything in the community with staff assaulting FC #23. -It was never reported that anyone saw staff #1 assaulting FC #23 when he left the facility on 5/12/24. -Nurse #1 and staff #2 never said anything to her about staff #1 assaulting FC #23 while they were out in the community. 2. Review on 6/18/24 of FS #11's personnel record revealed: -Date of hire was 2/27/23 -Hired as a Residential Advisor. -He was terminated on 12/14/23. Review on 6/18/24 of FC #22's record revealed: -Admission date of 7/13/23. -Diagnoses of Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Autistic Disorder and Attention Deficit Hyperactivity Disorder. -He was 11 years old. -He was discharged on 2/18/24. Review on 6/18/24 of a police report dated 12/15/23 revealed: -"On 12/15/23 I was contacted by [the PD] of Canyon Hills. She stated another resident said that [FS #11] assaulted him. I spoke with [FC #22] who stated that [FS #11] pushed him then punched him in the stomach. [FC #22] also stated	V 512		

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V 512	Continued From page 44 that [FS #11] grabbed him by his arm and bent his wrist for pain compliance. [FS #11] then walked him to his room where he let him go..." Review on 6/25/24 of a Health Care Personnel Registry (HCPR) 24-Hour Initial Report dated 12/15/23 revealed: -The facility reported an allegation of abuse against FS #11 related to FC #22. Attempts on 6/19/24 and 6/21/24 to interview FC #22 revealed: -FC #22's guardian was contacted via telephone and did not answer. -There was a message stating "the party you are trying to reach is temporarily unavailable." -Voicemail message and/or text message option was not available. -The phone call was never returned by FC #22's guardian prior to the exit on 7/3/24. An attempt on 6/20/24 to interview FS #11 revealed: -He was contacted via telephone and did not answer. -A text message was sent requesting the phone call be returned. -The phone call was never returned prior to the exit on 7/3/24. Interview on 6/19/24 with staff #2 revealed: -In December 2023 (12/11/23) there was an incident with FS #11 and FC #22. -FC #22 had a behavior. -He and FS #11 escorted FC #22 to his bedroom. -They stood near the bedroom door. -He saw "[FS #11] push [FC #22] into the bedroom." -'[FS #11] pushed [FC #22] in his back and [FC #22] fell onto his bed."	V 512		

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V 512	Continued From page 45 Interview on 6/19/24 with staff #3 revealed: -She witnessed the incident with FS #11 and FC #22 in December 2023 (12/11/23). -FC #22 was in his bedroom because he had a behavior. -She saw FS #11 go into FC #22's bedroom. -She then heard FC #22 yell out "you hit me." -"I heard a hit but didn't see [FS #11] actually hit [FC #22]." -The Former Registered Nurse (FRN) also witnessed those incident. -She talked with the FRN and the FRN reported the incident to upper management. Interview on 6/20/24 with the FRN revealed: -She witnessed the incident with FS #11 and FC #22 in December 2023 (12/11/23). -FS #11 went to assist another staff escort FC #22 into his bedroom. -She saw FS #11 bend FC #22's wrist back "really far." -FS #11 then "shoved" FC #22 into his bedroom. -FC #22 hit something in his bedroom because she heard a loud "thud like noise." -FC #22 then started crying. -She reported the incident immediately to the Director of Nursing, the Program Director and Facility Manager. Interviews on 6/19/24 and 6/25/24 with the Program Director revealed: -She was aware of the incident with FS #11 and FC #22. -The Former Nurse brought that incident to her attention because she witnessed the incident. -Once the incident came to her attention FS #11 was suspended. -FS #11 was later terminated. -She recalled doing the investigation for that	V 512		

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incident.
-She wasn't sure why there was no documentation related to the investigation for the FS #11 and FC #22 incident in December 2023.

Review on 6/25/24 of a Plan of Protection written by the Program Director dated 6/25/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Canyon Hills staff members will be removed immediately from the premises. Treatment Facility will follow the guidelines of incident reporting in the event of allegations of abuse. Describe your plans to make sure the above happens. One staff member has been suspended as well as terminated. The other staff member has been suspended and currently being investigated. In the event of an re-occurrence, Canyon Hills Treatment Facility will immediately removed. Staff from the facility, contact law enforcement, Department of Social Services and Health Care Personnel Registry (HCPR). Canyon Hills will file an 24-hr (hour) report with HCPR as well as file an incident report in Incident Response Improvement System (IRIS). Canyon Hills will provide training on abuse to all staff."

Clients diagnoses included Post Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Autistic Disorder, Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. On 5/12/24 FC #23 eloped from the facility, jumping over the fence and leaving the facility grounds. FC #23 ran down the highway near to the facility. Staff #1, staff #2 and Nurse #1 left the facility and followed FC #23. Three witnesses in the community saw FC #23 tackled to the ground by staff. Two of the community witnesses saw staff #1 punch FC #23 in his side. After the incident FC #23 had multiple scrapes all

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V 512	Continued From page 47 over his body. The area FC #23 said staff #1 hit was red and had some swelling. On 12/11/23 FC #22 had a behavior and was escorted to his bedroom by staff #2 and FS #11. FS #11 bent back FC 22's hand and pushed FC #22 into his bedroom. FC #22 fell onto his bed as a result of being pushed by FS #11. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days.	V 512		