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V 000	INITIAL COMMENTS A complaint and limited follow up survey for the Type A1 and Type B was completed on 8/26/24. This was a limited follow up survey, only 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) and 10A NCAC 27G .1902 Psychiatric Residential Treatment for Children and Adolescents-Staff (V315) were reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G .1902 Psychiatric Residential Treatment for Children and Adolescents-Staff (V315). The complaints were substantiated (intake #NC00219510, #NC00220070 and #NC00220076). 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 5 current clients and 1 former client.	V 000		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address	V 314		

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V 314	Continued From page 1 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/. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to coordinate client care with other	V 314		

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V 314	Continued From page 2 individuals and agencies affecting one of five audited current clients (#2). The findings are: Review on 8/14/24 of client #2's record revealed: -Admission date of 3/7/24. -Diagnoses of Conduct Disorder, Generalized Anxiety Disorder, Alcohol Use Disorder and Cannabis Use Disorder. -He was 14 years old. Review on 8/14/24 of Child and Family Team (CFT) Notes revealed: -Meetings were held on 5/8/24 and 5/22/24. -There was no CFT note for 6/26/24. Interview on 8/15/24 with client #2's guardian revealed: -"We have issues with this facility when it comes to CFT meetings." -The CFT meetings are supposed to be held every 30 days. -The facility was "constantly" changing the dates of the CFT meetings. -"Sometimes we don't know the date has changed until the very last minute." -There was a CFT meeting scheduled for 6/26/24. -She and the Guardian Ad Litem Supervisor for client #2 drove for over 3 hours to the facility. -When they showed up to the facility there was no meeting. -She talked to the Program Director prior to the planned 6/26/24 meeting and was told a link for the video conference would be sent for that meeting. -The link for the video conference was never sent and there was no one available onsite on 6/26/24 for the CFT meeting. -There was no CFT meeting for client #2 in June 2024.	V 314		

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V 314	Continued From page 3 -In April 2024 the CFT meeting was originally scheduled for 4/4/24. -The facility later changed the CFT meeting to be held on 4/17/24. -The meeting was rescheduled again by facility staff and was held on 4/18/24. -A CFT meeting was scheduled for 5/8/24. -Facility staff changed the meeting to 5/16/24 via zoom. -The facility changed the May 2024 CFT meeting again to 5/31/24. -There was a CFT meeting scheduled on 7/12/24 via zoom, however no one from the facility was present online for the meeting. -When facility staff was questioned, she was told the Former Qualified Professional/Case Manager (FQP/CM) was out sick. -The July 2024 CFT was rescheduled for 7/16/24. Interview on 8/15/24 with client #2 revealed: -He did not have a CFT meeting in June 2024. -His guardian came to the building for the meeting. -He was told the meeting was canceled because the facility had no therapist available that day. -He was also told some of the other staff that would normally attend the CFT were not available. Interview on 8/14/24 with the Program Director revealed: -CFT meetings are held for each client every 30 days. -They do a CFT meeting form about topics discussed during the meeting. -She was aware there was no CFT meeting held in June 2024 for client #2. -"It was my understanding the FQP/CM rescheduled the CFT meeting because she was not feeling well in June 2024."	V 314		

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V 314	Continued From page 4 -The FQP/CM was responsible for coordinating the CFT meetings each month. -She wasn't sure why the FQP/CM kept changing the dates for some of the CFT meetings. -The FQP/CM just recently resigned from the facility. -She didn't attend CFT meetings consistently as the Program Director. -The Director of Nursing, QP/CM and Therapist are all required to attend CFT meetings. -She only attended CFT meetings if a QP/CM was not available.	V 314	The agency will ensure that each client receives a CFT meeting monthly after admission. The clinical team will be responsible for promptly scheduling and notifying the team members via email. One of the clinical team members will immediately reschedule any missed meetings. The Executive Director will ensure the meetings occur at least monthly and participate in and/or conduct meetings as needed. Policy and procedures regarding treatment planning will be reviewed for necessary updates.	9/15/24
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 (a) through (d) of this Rule shall be grounds for dismissal of the employee.	V 512		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, one of one audited Former Staff (FS) (#7) abused one of five audited clients (#1). The findings are:

1. Review on 8/14/24 of FS #7's personnel record revealed:
-Date of hire was 10/6/23.
-Hired as a Residential Advisor.
-Termination date was 8/1/24.

Review on 8/14/24 of client #1's record revealed:
-Admission date of 5/28/24.
-Diagnoses of Adjustment Disorder, Oppositional Defiant Disorder, Anxiety Disorder and Major Depressive Disorder.
-He was 15 years old.
-Comprehensive Clinical Assessment dated 5/28/24-"[Client #1] has a history of displaying physical aggression and utilizing illegal substances. Since arriving at Canyon Hills, [client #1] has demonstrated both physical and verbal aggression towards staff and his peers. [Client #1] continues to struggle with utilizing profanity and had displayed disruptive behaviors..."

Review on 8/14/24 of an in-house incident report dated 7/27/24 revealed:
-"At approximately 1:10 pm, [client #1] was in the nurse's office getting his height and weight done. [Registered Nurse (RN)] then asked [client #1] to sit down to get his blood pressure checked. [Client #1] stated, I don't know why I have to do this s**t. [Client #1] refused to get his blood pressure taken. [RN] and [FS #7] walked onto the unit with [client #1]. [FS #7] then picked up [client

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#1's] cards of the table. [Client #1] began to use profanity towards [FS #7]. [Client #1] walked over to the television (tv) and sat down. [Client #1] began to have a verbal altercation with [FS #7]. [Client #1] then stuck up his middle finger at [FS #7]. [FS #7] walked over towards [client #1] [Client #1] took his shoulder and brushed it up against [FS #7]. [FS #7] and [client #1] continued to exchange words. [Client #1] then stood up and walked up to [FS #7] and got in his face and pushed him. [FS #7] then pushed [client #1] away from him. [Therapist #1] asked [FS #7] to walk away. [Client #1] continued to be physically aggressive towards [FS #7] by charging towards him again. [Client #1] and [FS #7] fell to the floor during the scuffle, [FS #7] and [client #1] got off the floor. [FS #7] at that time was walking towards the door to exit the unit. [Client #1] was being verbally aggressive towards [FS #7], by cursing and yelling at him. [FS #7] turned around and attempted to hit [client #1]. [FS #7] then walked off the unit and left the facility ...Assessed [client #1], multiple scratches noted to neck and abrasion noted to face. [Client #1] refused further assessment."

Attempted interviews on 8/15/24 and 8/19/24 with client #1 revealed:
-He refused to be interviewed.

Interview on 8/15/24 with client #3 revealed:
-He witnessed the incident with client #1 and FS #7 in July 2024 (7/27/24).
-Client #1 got in FS #7's face and bumped FS #7 in his chest "hard."
-"[FS #7] grabbed [client #1] by his shoulders and moved [client #1] out of his space."
-"[Client #1] then swung at [FS #7] and missed."
-Client #1 then punched FS #7.
-Client #1 tripped and fell onto the floor.

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V 512	Continued From page 7 -FS #7 went down to the floor and held client #1 in "a bear hug position" while they were on the floor. -FS #7 sat on the floor while he held client #1 in "the bear hug position." -FS #7 then got off the floor and grabbed his "stuff" and started walking off the unit. -As FS #7 was walking off the unit client #1 pushed FS #7 in his back. -"[FS #7] was really mad and then pushed [client #1] forcefully into the wall and held him there for about 20 seconds." -He did not see FS #7 punch or hit client #1 during that incident. Interview on 8/15/24 with client #6 revealed: -He witnessed some of the incident with client #1 and FS #7 at end of July 2024 (7/27/24). -Client #1 was "mad and kept pushing [FS #7]." -Client #1 also "punched" FS #7. -"[FS #7] went off and [FS #7] pushed [client #1] forcefully." -Staff had to separate client #1 and FS #7. -He could not remember which staff separated client #1 and FS #7 during that incident. Interview on 8/15/24 with client #7 revealed: -He witnessed the incident with client #1 and FS #7 in July 2024 (7/27/24). -"[Client #1] swung on [FS #7] and punched him in the face." -"[FS #7] pushed [client #1] into the wall a few times because [client #1] just kept messing with him." -"[FS #7] then slammed [client #1] onto the floor." -"[FS #7] was on his knees and hovering over [client #1] whenever he slammed him on the floor." -"Staff did try to intervene, but they could not do anything with [FS #7] and [client #1]."	V 512		

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-"I put [client #1] in a choke hold and held him on the floor."
-He never saw FS #7 hit or punch client #1 during that incident.

Interview on 8/14/24 with FS #7 revealed:
-There was an incident towards the end of July 2024 (7/27/24) with client #1.
-Client #1 was refused to take his medication while they were on the unit.
-He told client #1 he needed to take his medication.
-Client #1 played a card game with some of the other clients and did not want to stop playing.
-"[Client #1] ignored me and just kept playing cards."
-He took the cards away from client #1 and told him again he needed to take his medication.
-Client #1 "cussed" at him when he took the cards away from him.
-He told client #1 to go to his bedroom and he refused.
-Client #1 said "I'm not doing anything or going anywhere."
-'[Client #1] then stood up and put his middle finger into my face."
-He turned his back to walk away from client #1 and client #1 hit him in the back of his head.
-Client #1 knocked his cap off his head.
-"I then pushed [client #1], I pushed him a little forcefully."
-"I let go of [client #1], grabbed my belongings and left the facility."
-He never hit or punched client #1 during that incident
-He never returned to the facility after that incident.
-He quit the same day of that incident on 7/27/24.
-When he went to the facility on 8/1/24 to get his check, the Facility Administrator informed him he

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V 512	Continued From page 9 was terminated. Interview on 8/14/24 with staff #1 revealed: -She witnessed the end of the incident with FS #7 and client #1 on 7/27/24. -She was eating lunch in a break area on unit. -She heard a loud commotion as she was finishing up her lunch. -She looked up when she heard the commotion. -She saw staff #3 and the RN when they were separating client #1 and FS #7. -She did not see FS #7 hit client #1. -She did see scratches on client #1's neck and shoulder area after that incident. Interview on 8/15/24 with staff #2 revealed: -She witnessed the incident with FS #7 and client #1 in July 2024 (7/27/24). -Client #1 was playing cards with some of the other clients. -Client #1 did not want to go to the nursing station to get his medication. -"[FS #7] told [client #1] to stop playing cards and go to the nursing station about 3 times." -Client #1 started "cussing" at FS #7. -FS #7 took the cards and said "no one will play." -Client #1 kept "cussing" and staff told him to stop "cussing." -Client #1 then got into FS #7's face and put his middle finger near FS #7's nose. -FS #7 moved client #1's hand out of his face. -Client #1 was still "cussing." -Client #1 then stood behind FS #7's head and spit at him. -FS #7 then grabbed client #1 by both of his wrists. -Client #1 went down to the floor and started kicking. -FS #7 was "hovering" over client #1 on his knees while he was on the floor holding his arms to	V 512		

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keep client #1 from fighting.
-Client #1 was laid on his back while he was on the floor.
-"They may have been on the floor for less than a minute."
-The RN then came onto the unit.
-"[FS #7] got off the floor, grabbed his things and left the unit."
-"Other staff tried to de-escalate the situation by separating the other kids (clients) and telling [client #1] to calm down."
-She never saw FS #7 hit or punch client #1 during that incident.
-She did not recall seeing any bruises and scratches on client #1 after that incident.

Interview on 8/15/24 with staff #3 revealed:
-He did witness some of the incident on 7/27/24 with FS #7 and client #1.
-When he walked into the common area he saw client #1 stand behind FS #7.
-Client #1 head butted FS #7 and spit on him.
-"[RN] then walked onto the unit and by that time the incident was over."
-He never saw FS #7 hit or punch client #1.

Interview on 8/16/24 with a staff revealed:
-Witnessed the incident with client #1 and FS #7 on 7/27/24.
-Saw FS #7 and client #1 at nursing station and client #1 had "an attitude."
-Client #1 started getting "mouthy" with FS #7.
-We all walked back onto unit and client #1 and FS #7 "kept talking back and forth."
-"I then went to talk to another client on the hallway near that client's bedroom."
-"A few minutes later I heard a loud commotion."
-"I heard yelling, chairs moving and bumping."
-"I ran to the common area of the facility and saw [client #1] and [FS #7] wrestling."

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-They were both stood and pulled at each other.
-Client #1 tried to hit FS #7.
-"I grabbed [FS #7] and told him he was messing up and needed to leave the situation."
-Another staff grabbed client #1.
-"I was holding [FS #7] and pushed him back."
-"I let go of [FS #7] and [FS #7] went into the staff closet and grabbed his stuff."
-FS #7 said he was leaving the facility.
-FS #7 then turned around and swung at client #1 while another staff was holding client #1.
-"I could not tell if [FS #7] hit [client #1]."
-Client #1 and FS #7 were both using profanity during this incident.
-"I saw redness and scratches on [client #1's] neck and shoulder areas after that incident."

Interview on 8/16/24 with the RN revealed:
-She recalled the incident with client #1 and FS #7 on 7/27/24.
-She was doing vital signs and weights with the clients.
-She was walking back and forth on the unit, getting the clients and then taking them to the nursing station.
-Client #1 was on the unit sitting and watching tv.
-She then heard "a verbal altercation between [client #1] and [FS #7]."
-Client #1 and FS #7 were "arguing back and forth."
-Client #1 then jumped up and pushed his chest up against FS #7's chest.
-FS #7 put up his arm and blocked client #1 with his hand and pushed client #1 away.
-She didn't recall how forceful the push was when FS #7 pushed client #1 away.
-FS #7 then walked away and went into the staff closet and got his belongings.
-"As [FS #7] was leaving the unit he turned around and swung at [client #1]."

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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 512	Continued From page 12	V 512		

-"I didn't know if [FS #7] hit [client #1] when he swung at him."
-"I attempted to assess [client #1] after the incident, however he refused to let me do a full assessment."
-Client #1 told her to get out of his room.
-She could not remember if client #1 had any bruises after that incident.
-"[Client #1] had a few scratches on his neck and shoulder areas."

Interview on 8/14/24 with the Facility Manager revealed:
-He did not witness the incident with client #1 and FS #7 on 7/27/24.
-"By the time he got on the unit [FS #7] had already walked out of the facility."
-He had no chance to tell FS #7 to leave the facility due to the incident with client #1.
-"According to other staff, [FS #7] said he quit and was not returning to the facility."
-FS #7 never returned to the facility after that incident.
-Staff told him about the incident with client #1 and FS #7 while he was on the unit.
-He was told client #1 was refusing to take his medication.
-He was told FS #7 told client #1 he needed to take his medication and client #1 got into FS #7's face.
-He was told "[FS #7] and [client #1] got into a shoving match."
-Staff said "both [client #1] and [FS #7] were throwing punches at each other."
-Staff did not specify were FS#7 punched client #1.
-He reported the incident to the Program Director the same day it came to his attention.

Interview on 8/14/24 with the Program Director

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	MHL047-158	A. BUILDING: _____ B. WING _____	C 08/26/2024

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revealed:
-She was aware of the incident in July 2024 (7/27/24) with client #1 and FS #7.
-She was told by staff client #1 got into FS #7's face and they then got into a physical altercation.
-She was told FS #7 hit client #1 in his face.
-"Staff really didn't specify how [client #1] was hit."
-Staff told the Facility Manager about the incident shortly after incident occurred.
-The Facility Manager called her about the incident.
-"[The Facility Manager] informed [FS #7] he needed to leave the premises."
-They "immediately" did the investigation for that incident.
-Health Care Personnel Registry and the Department of Social Services were also contacted.
-They did substantiate the allegation of abuse and FS #7 was terminated.
-They did a training on August 2, 2024 to address that incident (7/27/24).

2. Review on 8/20/24 of the Statement of Deficencies for facility dated 7/3/24 revealed:
-On 5/12/24 former client (FC) #23 eloped from the facility, jumped over the fence and left the facility grounds.
-FC #23 ran down the highway near the facility and was followed by 3 facility staff.
-Three witnesses in the community saw FC #23 tackled to the ground by the facility staff.
-Two of the community witnesses saw FS #7 punch the former client in his side.
-After the incident FC #23 had multiple scrapes all over his body.

Review on 8/19/24 of an Investigation Summary dated 6/19/24 revealed:
-The facility was informed on 6/19/24 by the

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V 512	Continued From page 14 Division of Health Service surveyor there was allegation against FS #7. -The incident occurred in May 2024 (5/12/24) in the community. -The facility initiated an investigation on 6/19/24 involving FC #23 and FS #7. -FC #23 alleged FS #7 assaulted him. -After the investigation it was determined that FS #7 could return to work at the facility. -There was nothing in the Investigation Summary regarding training for FS #7. Interview on 8/14/24 with FS #7 revealed: -He was suspended in June 2024 (6/19/24) due to the incident with FC #23. -He was suspended from working in the facility while the facility did their internal investigation. -He returned to work to the facility from his suspension at the beginning of July 2024. -He did not recieve any type of training in regard to to the incident involving him assaulting FC #23 after returning from his suspension in July 2024. Interviews on 8/14/24, 8/15/24 and 8/19/24 with the Program Director revealed: -She could not remember the specific date FS #7 returned from suspension in June 2024 after the May 2024 incident with FC #23. -FS #7 returned to the facility shortly after the completion of the July 3, 2024 survey. -They did an abuse, neglect and exploitation training in July 2024 (7/19/24) to address the Type A1 violation that was issued to the facility on July 3, 2024. -FS #7 did not attend the training on July 19, 2024. -They normally do staff trainings on Fridays. -FS #7 was not scheduled to work on the day of the training. -"Sometimes it's hard ensuring all of the staff are	V 512		

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V 512	Continued From page 15 trained on the same day." Review on 8/15/24 of a staff training roster dated for 7/19/24 revealed: -FS #7 name was listed on the training roster -There was no signature to indicate FS #7 attended, participated or completed the training. Review on 8/26/24 of a Plan of Protection written by the Facility Administrator dated 8/26/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The facility will ensure that clients are protected from harm, abuse, neglect or exploitation in accordance with 10A NCAC 27D. 0304. Facility will conduct monthly training specific to education staff and clients on the following: Definition of abuse, neglect and exploitation; How to recognize abuse, neglect and or exploitation; A signature page of attendance will serve as verification of completed training; The training provided will be offered to each population separately. Staff members will not be returned to work until training has been completed with verification by the signature sheet. Person Responsible: Facility Administrator or he/she designee. Describe your plans to make sure the above happens. To ensure compliance the Facility Administrator or he/she designee, will be responsible for conducting and documenting all training." Client's diagnoses included Adjustment Disorder, Oppositional Defiant Disorder, Anxiety Disorder and Major Depressive Disorder. On 7/27/24 there was an incident on the unit with client #1 and FS #7. Client #1 refused to go to the nursing station. FS #7 and client #1 had a verbal altercation due	V 512		

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V 512	Continued From page 16 to client #1's refusal to go to the nursing station. The verbal altercation escalated into a physical altercation between FS #7 and client #1. FS #7 pushed client #1, put him in a bear hug on the floor, slammed client #1 onto the floor and swung at client #1 during this incident. Other staff on the unit had to separate FS #7 and client #1. Client #1 had some redness and scratches on his neck and shoulder areas after the incident. On 6/19/24 facility management staff conducted an investigation for an allegation of assault against FS #7 towards a former client. The former client alleged FS #7 assaulted him during an incident on 5/12/24 in the community. Witnesses in the community saw FS #7 tackle and punch the former client. FS #7 was suspended on 6/19/24 and returned to the facility at the beginning of July 2024. The facility received a Type A1 violation on 7/3/24. The facility conducted a staff training on 7/19/24 in response to the incident, however FS #7 did not attend the training. The facility did not have a make-up training for FS #7. The facility failed to ensure FS #7 received any training in response to the Type A1 violation issued on 7/3/24, although FS #7 was the staff involved in the incident with the former client on 5/12/24. This deficiency constitutes a Continuing Type A1 rule violation originally cited for serious abuse for failure to correct within 23 days.	V 512	FS staff #7 completed re-training on 6/27/24. Any staff member involved in investigations regarding abuse and/or neglect will be removed from facility immediately pending investigation and recommendations from Corporate Compliance and/or Executive Director that may or may not include retraining.	9/1/24