STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL047-158	B. WING		08/06/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CANYON	I HILLS TREATMENT	FACILITY	RDEEN ROAI D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	TS	V 000			
	A complaint and follow survey was completed on August 6, 2025. The complaint (intake #NC00232705) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 1900. Psychiatric Residential Treatment for Children and Adolescents This facility is licensed for 24 and currently has a census of 21. The survey sample consisted of audits of 3 current clients and 2 former clients.					
V 314	.1901 Psych Res. 1	Гх. Facility - Scope	V 314			
	SECTION .1900 -PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR CHILDREN AND ADOLESCENTS 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to based 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 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					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

AND DUAN OF CODDECTION		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	MHL047-158		B. WING		08/06/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CANYON	I HILLS TREATMENT	FACILITY	RDEEN ROAL			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	D, NC 28376	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
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V 314	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 observation, record reviews, and interviews the facility failed to ensure it operated within the scope of a psychiatric residential treatment facility (PRTF) affecting 1 of 5 current clients (Client #1) and 1 of 2 former clients (Former Client #4). The findings are: Review on 8/6/25 of the facility's license revealed: -The facility was licensed as a .1900 Psychiatric Residential Treatment for Children and Adolescents.		V 314			
	Health Developmer	f the Rules for Mental Health ntal Disabilities and Substance d Services revealed:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	MHL047-158		B. WING		08/0	06/2025	
NAME OF I	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE	,	
CANYON	N HILLS TREATMENT	FACILITY		RDEEN ROAI			
- CARTOI	THEE TREATMENT	TAGIETT 1	RAEFORI	D, NC 28376			
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V 314	Continued From pa	age 2		V 314			
	-""(b) A PRTF is on children or adolesc or substance abuse inpatient setting." -""Child" means a r years of age." -""Adolescent" mea years of age."	ents who have me e/dependency n a minor from birth thi	ental illness non-acute rough 12				
	Review on 8/6/25 of Client #1's record revealed: -Admission date of 3/9/23Date of birth 9/2/06He was 18 years, 11 months oldDiagnoses of Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder; Unspecified Trauma or Stress Disorder.						
	Review on 8/625 of Former Client #4's record revealed: -Admission date of 11/8/24Discharge date of 7/10/25Date of birth 3/27/07He was 18 years, 3 months old at time of dischargeDiagnoses of Attention Deficit-Hyperactivity Disorder; Disruptive Mood Dysregulation Disorder; Post-Traumatic Stress Disorder; Adjustment Disorder with Depressed Mood.						
	Interview on 8/6/25 -He had been at the He was 18 years of the was going to go planning to live on the was planning to TechnologyHe felt well treated left respected left in the He had had no fight in the head had no fight.	e facility for 3 year old. o to college 8/15/2 campus. o study Information d and safe at the factory staff and his perfer brother" to his perfer brother.	s. 25 and was n acility. ers. peers.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL047-158		B. WING		08/06/2025	
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		FAOULTV		RDEEN ROAL			
CANYON	I HILLS TREATMENT	FACILITY	RAEFORI	D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC / MUST BE PRECEDED E SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 314	Continued From pa	ge 3		V 314			
	-He had seen fights usually stopped the -He took medication regularly, with no is -He participated in a weekHe still had a guard and was in the 18-2 programHe was expecting college on 8/15/25. Interview on 8/6/25 -He had been at the -He felt respected by facilityHe had seen fights always broken up be -Client #1 was not in witnessed.	s but not recently, as m quickly. In and would get the sues. Itherapy regularly, a dian through Social 21 year old Foster (and the sues as istance) with Client #2 reverse facility for about 4 by staff and felt safes between peers but ye staff fast.	em daily, at least once I Services Care moving to ealed: months. e in the				
	Interview on 8/6/25 -Had been at the far as "has been goodHe felt safe and fe -He had seen peers but staff breaks it -He had not seen County Interview on 8/6/25 revealed: -"As of today, I'm not [Client #1]." -She was not current for Client #1She was letting the dothe searching ar she and the care of place for Client #1, voiced that he did not seen the searching ar she and the care of place for Client #1, voiced that he did not seen the searching ar she and the care of place for Client #1, voiced that he did not seen the searching ar she and the care of place for Client #1, voiced that he did not seen the searching ar she and the care of place for Client #1, voiced that he did not seen the searching ar she searching ar	cicility 8 months, and " It treated with response get in fights "som up." Client #1 getting into with Client #1's leg of aware of any pla ently searching for pe e facility and care co and placement of Cli coordinator had init but him being 18 y	d reported ect by staff. etimes of fights. gal guardian cement for lacement oordinator ent #1. ially found a ears old, he				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL047-158		o. I`´	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		B. WING		08/	06/2025	
	PROVIDER OR SUPPLIER N HILLS TREATMENT	FACILITY 769	REET ADDRESS, CITY, S B ABERDEEN ROAL BEFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 314	they had to respect -She was told by the for him to stay "outs obviously, that was calls from him and facility." -She was not sure transitioned out of the she did not know the nextFacility also told he hoke CountyShe and the care of searching for place. Interview on 8/6/25 -He loved working the loved working the loved working the searching for place. Interview on 8/6/25 -He loved working the loved	it. e facility that they had a paide of the facility, but not so, because I still recthey are coming from the why Client #1 has not be he facility. where he would be going er that they had a place in coordinator would be actiment for Client #1 again. with Staff #6 revealed: with Client #1. good with others. He folles not get in trouble. He cont hurt a fly!" with the Facility Manage thy Client #1 was still at the pay salary." en very good. He does not fight with others. Stay at the staff. Completes his problems at all this year with the Corporate evealed: e that Client #1 needed to	ceive en to n vely ows does r ne ot get s out s :"			

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AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	MHL047-158		B. WING		08/0	6/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CANYON	I HILLS TREATMENT	FACILITY	DEEN ROAI D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 314	immature for his ag-"We are currently treatment team. It's manager. They had they new one inher -"[Client #1] would if facility. He is not ab-"The plan is to moliving facility." -The Qualified Prof leave as he had de-The Qualified Prof transitioning Client treatment team. -She was aware the placement for Client ransition him out, thim. -Client #1 continued coordinator. -"[Client #1] is not a does not fight with any fights this year. -"[Client #1] tries to not a threat. He has other kids in the proshe was also aware accepted to go to F-"Classes are suppthing [Client #1] wo dorms." -She also did not kin be starting classes -Regarding Former why he was transition birthday.	versing with [Client #1]'s been difficult with his care I changed social workers and ited the case." heed to go to an assisted living ble to care for himself." ve him out to a supervised essional was out on family ath in his family. essional was in charge of #1 in conjunction with the at they had previously found a at #1, but when it was time to he facility declined to have d to receive visits from his care a problem at the facility. He the other kids and has not had " stay away from trouble. He is s had no incidents with the orgam." re that Client #1 had been ayetteville State University. osed to start soon, but I don't uld be moving in to the how if Client #1 would actually	V 314			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL047-158	B. WING		08/	06/2025
	PROVIDER OR SUPPLIER	769 AB	ADDRESS, CITY, S			
CANYON	I HILLS TREATMENT	FACILITY	ORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 736	Continued From pa	ige 6	V 736			
V 736	.0303(c) Facility an	d Grounds Maintenance	V 736			
	exterior requirements (c) Each facility and maintained in a saf manner and shall b odor.	d its grounds shall be e, clean, attractive and order e kept free from offensive	ly			
	This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe, clean and attractive manner. The findings are:					
	revealed: Unit A -Common area: mu missing throughout Hall: a hole approxi under the emergen -1st Bedroom on th ceiling approximate clothing.) -1st bedroom on rig flooring missing pie missing, door frame side, door frame be -2nd Bedroom on ri laminate flooring st doorway4th Bedroom on le laminate flooring st into doorway.	imately 2"x1" was in the wall cy lighting. he left side of hall: hole in the lay 8"x6" (filled with a piece of a ght side of hall: laminate leces in front of door, door e missing on top and right	j ,			
	missing from right s	strips of laminate flooring side of room, 2 strips of issing from left side of room.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:). I ` `	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL047-158	B. WING		08/	06/2025
NAME OF	PROVIDER OR SUPPLIER		REET ADDRESS, CITY, S	•		
CANYO	N HILLS TREATMENT	FACILITY) ABERDEEN ROAL EFORD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 736	-Hall: a hole approxunder the emergen -1st Bedroom on the veneer peeling from -1st Bedroom on the flooring missing piedoorway3rd Bedroom on rigeth bedroom on leddoorknob. Interview on 8/6/25 revealed: -Facility would be mupcoming weeksCurrent building we to the new highway. No major repairs hannual survey companded as the building and demolished in the acknowledged maintained in a safemanner. Interview on 8/6/25 Compliance staff refracility was plannif building as soon as got completed"Surveyor from the building yesterday at Licensure to do the -She was hoping to 9/1/25No major repairs we location as it would move out.	climately 4"x2" was in the cy lighting. e right side of hall: wood in the door. e left side of hall: laminate ces from hallway into the ght side of hall: door miss ft side of hall: missing with the Facility Managel moving to a new building it ould be demolish to make being built. In ad been made since the pleted in June. I rent plans to repair items ilding would be closing do the near future. I the facility failed to be e, clean and attractive with the Corporate evealed: Ing to move into the new is all the licensing procedure. The Construction went by the land we are now awaiting	r n the e way			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED			
		MHL047-158	B. WING		08/0	06/2025		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 769 ABERDEEN ROAD RAEFORD, NC 28376							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
V 736	maintained in a safe manner.	e, clean and attractive	V 736					

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