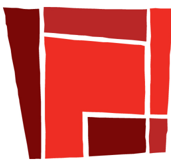

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

Statement of Deficiencies

Survey Date - 2/16/2023

STEP TWO RECOVERY CENTER

3771 EAST BROOKS FARM ROAD
GILBERT, AZ 85298
(480) 988-3376

Facility ID: BH2607

License: BH2607

The following deficiencies were found during the compliance inspection and investigation of complaint #AZ00190974 conducted on February 16, 2023:

Findings Report Summary

Findings for: Citation 1 **Corrected Date:** 04/27/2023	**Rule/Statute:** Health care institutions; fall prevention and **Rule Text:** 36-420.01. Health care institutions; fall prevention and fall recovery; training programs; definition A. Each health care institution shall develop and administer a training program for all staff regarding fall prevention and fall recovery. The training program shall include initial training and continued competency training in fall prevention and fall recovery. A health care institution may use information and training materials from the department's Arizona falls prevention coalition in developing the training program.	**Survey Text:** **A.R.S. § 36-420.01.A~** Based on documentation review, record review and interview, the health care institution failed to develop and administer a training program for all staff regarding fall prevention and fall recovery. The deficient practice posed a risk as the Department was unable to determine substantial compliance as the required documentation was not provided during the inspection, and was not provided to the Department within two hours after a Department request. Findings include: 1. A review of facility documentation revealed no training program for fall prevention and fall recovery. 2. A review E1's, E2's, E3's, E4's, E5's, E6's, E7's and E8's personnel records revealed no initial training or continued competency training in fall prevention and fall recovery. 3. In an interview, E1 acknowledged a training program for fall prevention and fall recovery training was not available for review. E1 reported to be unaware of this requirement.
Findings for: Citation 2 **Corrected Date:** 02/17/2023	**Rule/Statute:** Personnel **Rule Text:** B. An administrator shall ensure that: 2. A personnel member's skills and knowledge are verified and documented: a. Before the personnel member provides physical health services or behavioral health services, and	**Survey Text:** **R9-10-706.B.2.a~** Based on record review and interview, the administrator failed to ensure a personnel member's skills and knowledge were verified and documented before the personnel member provided behavioral health services, for one of nine personnel members sampled. The deficient practice posed a risk to the health and safety of residents if a personnel member was not qualified to work in a health care institution. Findings include: 1. A review of E9's personnel record revealed no documentation E9's skills and knowledge were verified before E9 provided behavioral health services. 2. In an interview, E1 acknowledged E9's verification of skills and knowledge were not verified before E9 provided behavioral health services.

Findings for:	Rule/Statute:	Survey Text:
Findings for: Citation 3 **Corrected Date:** 02/16/2024	**Rule/Statute:** Personnel **Rule Text:** B. An administrator shall ensure that: 3. Sufficient personnel members are present on a behavioral health residential facility's premises with the qualifications, experience, skills, and knowledge necessary to: c. Ensure the health and safety of a resident.	**Survey Text:** **R9-10-706.B.3.c~** Based on documentation review and interview, the administrator failed to ensure sufficient personnel members were present on a behavioral health residential facility's premises with the qualifications, experience, skills, and knowledge necessary to ensure the health and safety of a resident. The deficient practice posed a risk as a personnel member transported residents while under driving restrictions. Findings include: A.R.S. 41-1758.07(D) states, "D. A person who is awaiting trial on or who has been convicted of committing or attempting to commit a misdemeanor violation of section 28-1381, 28 -1382 or 28-1383 in this state or the same or a similar offense in another state or jurisdiction within five years from the date of applying for a level I fingerprint clearance card is precluded from driving any vehicle to transport employees or clients of the employing agency as part of the person's employment. The division shall place a notation on the level I fingerprint clearance card that indicates this driving restriction. This subsection does not preclude a person from driving a vehicle alone as part of the person's employment." 1. A review of E2's personnel record revealed E2 was hired in 2022, as a behavioral health technician. 2. A review of E2's personnel record revealed a valid fingerprint clearance card with an issue date in 2022. However, the back of the card stated, "Driving Restrictions per A.R.S. 41-1758.07(D)." 3. In an interview, E2 reported E2 drives residents on outings, including to the outpatient treatment center residents attend four times per week. E2 reported when E2 received the notice of driving restrictions from the Department of Public Safety, E2 did not understand what it meant and discussed it with management. E2 reported E1 said it was okay to continue transporting residents, and continued to do so. 4. In an interview, E1 acknowledged E2's fingerprint clearance card imposed driving restrictions on E2, and that E2 has been transporting residents. E1 reported to not have not been aware of what exactly the driving restrictions had meant, and reported to have discussed it with additional management personnel, who determined E2 could continue to transport residents.
Findings for:	**Rule/Statute:**	**Survey Text:**

Citation 4 **Corrected Date:** 02/20/2023	Personnel **Rule Text:** F. An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have more than eight hours of direct interaction per week with residents, provides evidence of freedom from infectious tuberculosis: 1. On or before the date the individual begins providing services at or on behalf of the behavioral health residential facility, and 2. As specified in R9-10-113.	**R9-10-706.F.1-2~** Based on documentation review, record review, and interview, the administrator failed to ensure a personnel member provided evidence of freedom from infectious tuberculosis (TB) on or before the date the individual began providing services at or on behalf of the behavioral health residential facility, and as specified in R9-10-113, for two of nine personnel members sampled. Findings include: 1. A review of the facility's personnel schedule revealed E3 and E9 were not on the facility's staffing schedule to work at the facility from January 16, 2023, through February 19, 2023. 2. During a facility tour, the Compliance Officers observed E9 working with residents at the facility. 3. A review of E3's personnel record revealed a document titled, "Mantoux Tuberculin Skin Test (PPD) Consent," dated June 30, 2020. The document indicated E3 was free from infectious tuberculosis on July 2, 2020. A review of E3's personnel record revealed no documentation of subsequent evidence that E3 was free from infectious tuberculosis. 4. A review of E9's personnel record revealed no documentation of evidence that E9 was free from infectious tuberculosis. 5. In an interview, E1 reported E3 primarily meets with residents at the outpatient treatment center. E1 reported E9 is behavioral health technician and employee of the outpatient treatment center. E1 reported E9 comes to the facility every Thursday to provide counseling to the residents. E1 acknowledged E3's and E9's personnel records did not contain current documentation that E3 and E9 were free from infectious tuberculosis, as specified in R9-10-113.
Findings for: Citation 5 **Corrected Date:** 02/17/2023	**Rule/Statute:** Personnel **Rule Text:** G. An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes: 3. Documentation of: c. The individual's completed orientation and in-service education as required by policies and procedures;	**Survey Text:** **R9-10-706.G.3.c~** Based on record review and interview, the administrator failed to ensure personnel records were maintained for each personnel member, employee, volunteer, or student which included documentation of the individual's completed orientation, for one of nine personnel members sampled. The deficient practice posed a risk if a personnel member was unable to meet a resident's needs. Findings include: 1. A review of E9's personnel record revealed no documentation of E9's completed orientation. 2. In an interview, E1 acknowledged E9's personnel

		record did not include documentation of the individual's completed orientation.
Findings for: Citation 6 **Corrected Date:** 02/25/2023	**Rule/Statute:** Personnel **Rule Text:** G. An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes: 3. Documentation of: e. The individual's compliance with requirements in A.R.S. §§ 36-411, 36-411.01, and 36-425.03, as applicable;	**Survey Text:** **R9-10-706.G.3.e**~ Based on record review and interview, the administrator failed to ensure a personnel record was maintained for each personnel member that included documentation of compliance with the requirements in A.R.S. §§ 36-411 and A.R.S. §§ 36-425.03, for eight of nine personnel members sampled. The deficient practice posed a risk if the employee was a danger to a vulnerable population. Findings include: 1. A review of E1's (hired in 2017) personnel record revealed no notarized form provided by the department certifying E1 was not awaiting trial on or had never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction. 2. A review of E2's (hired in 2022) personnel record revealed a valid fingerprint clearance card, however, no documentation of compliance with A.R.S. § 36-411(C)(1). A review of E2's personnel record revealed no notarized form provided by the department certifying E2 was not awaiting trial on or had never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction. 3. A review of E4's (hired in 2020) personnel record revealed a valid fingerprint clearance card, however, no documentation of compliance with A.R.S. § 36-411(C)(1). A review of E4's personnel record revealed no notarized form provided by the department certifying E4 was not awaiting trial on or had never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction. 4. A review of E5's (hired in 2015) personnel record revealed no notarized form provided by the department certifying E5 was not awaiting trial on or had never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or

jurisdiction. 5. A review of E6's (hired in 2015) personnel record revealed no notarized form provided by the department certifying E6 was not awaiting trial on or had never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction. 6. A review of E7's (hired in 2019) personnel record revealed a valid fingerprint clearance card, however, no documentation of compliance with A.R.S. § 36-411(C)(1)(2). A review of E7's personnel record revealed no notarized form provided by the department certifying E7 was not awaiting trial on or had never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction. 7. A review of E8's (hired in 2022) personnel record revealed no notarized form provided by the department certifying E8 was not awaiting trial on or had never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction. 8. A review of E9's (hired in 2022) personnel record revealed a valid fingerprint clearance card, however, no documentation of compliance with A.R.S. § 36-411(C)(1)(2). A review of E9's personnel record revealed no notarized form provided by the department certifying E9 was not awaiting trial on or had never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction. 9. In an interview, E1 acknowledged documentation of compliance with A.R.S. § 36-411(C)(1) for E2, E4, E7, and E9 and compliance with A.R.S. § 36-411(C)(2) for E7 and E9 were not available for review. E1 acknowledged E1, E2, E4, E5, E6, E7, E8, and E9 had not certified on notarized forms that they were not awaiting trial on or had never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction, and reported to not be

		aware of this requirement.
Findings for: Citation 7 **Corrected Date:** 02/17/2023	**Rule/Statute:** Personnel **Rule Text:** K. An administrator shall ensure that: 3. There is a daily staffing schedule that: a. Indicates the date, scheduled work hours, and name of each employee assigned to work, including on-call personnel members;	**Survey Text:** **R9-10-706.K.3.a~** Based on documentation review, observation, record review, and interview, the administrator failed to ensure a daily staffing schedule indicated the date and scheduled work hours of each employee assigned to work, including on-call personnel members, to include the the behavioral health professional (BHP) and the registered nurse (RN). Findings include: 1. A review of facility documentation revealed daily staffing schedules for January 16, 2023, through February 19, 2022. The staffing schedules indicated the date, scheduled work hours, and name of each employee assigned to work. However, the daily staffing schedules did not indicate if an RN or BHP was present at the facility or on-call. 2. During a facility tour, the Compliance Officers observed E9 at the facility working with residents. However, the daily staffing schedules did not indicate E9 would be present at the facility. 2. A review of E3's (hired in 2003) personnel record revealed E3 was the facility's contracted BHP. 3. A review of E5's (hired in 2015) personnel record revealed E5 was the facility's contracted RN. 4. A review of E6's (hired in 2015) personnel record revealed E6 was the facility's contracted RN. 5. A review of E9's (hired in 2022) personnel record revealed E9 was hired as a behavioral health technician (BHT). 6. In an interview, E1 reported E5 is the facility's contracted RN, however, moved out of state and was not available to be on-call to come to the facility if needed. E1 reported the on-call RN was E6. E1 reported E3 was the facility's BHP, however, works out of the outpatient treatment center and only meets with residents at the outpatient treatment center. E1 reported E9 was a BHT that comes to the facility to provide counseling to the residents every Thursday. E1 acknowledged the staffing schedules did not indicate the date and scheduled work hours of each employee assigned to work, including on-call personnel members, to include the the behavioral health professional (BHP) and the registered nurse (RN).
Findings for: Citation 8 **Corrected Date:** 02/17/2023	**Rule/Statute:** Personnel **Rule Text:** K. An administrator shall ensure that: 4. A behavioral	**Survey Text:** **R9-10-706.K.4~** Based on documentation review, record review, and interview, the administrator failed

	health professional is present at the behavioral health residential facility or on-call;	to ensure a behavioral health professional (BHP) was on-call. The deficient practice posed a risk if a qualified individual was not available to assess a residents behavioral health needs when needed. Findings include: 1. A review of facility documentation revealed daily staffing schedules dated January 16, 2023, through February 19, 2023. However, documentation to indicate a BHP was on-call was not available for review. 2. A review of E3's personnel record revealed E3 was hired as the BHP in 2003. 3. In an interview, E1 acknowledged E3 was the facility's BHP, but only meets with residents when they come to the outpatient treatment center four days per week.
Findings for: Citation 9 **Corrected Date:** 02/20/2023	**Rule/Statute:** Admission; Assessment **Rule Text:** A. An administrator shall ensure that: 6. Except as provided in subsection (E)(1)(a), a medical practitioner performs a medical history and physical examination or a registered nurse performs a nursing assessment on a resident within 30 calendar days before admission or within 72 hours after admission and documents the medical history and physical examination or nursing assessment in the resident's medical record within 72 hours after admission;	**Survey Text:** **R9-10-707.A.6~** Based on record review and interview, the administrator failed to ensure a medical practitioner performed a medical history and physical examination or a registered nurse performed a nursing assessment on a resident within 30 calendar days before admission or within 72 hours after admission and documented the medical history and physical examination or nursing assessment in the resident's medical record within 72 hours after admission, for three of six residents sampled. The deficient practice posed a risk to the health and safety of the residents as the residents' current physical health was not assessed prior to providing behavioral health services. Findings include: 1. A review of R1's medical record (admitted 2023) revealed a nursing assessment completed over 72 hours after R1 was admitted to the behavioral health residential facility. 2. A review of R3's medical record (admitted 2023) revealed a nursing assessment completed over 72 hours after R3 was admitted to the behavioral health residential facility. 3. A review of R4's medical record (admitted 2023) revealed a medical history and physical examination or nursing assessment was not available for review. 4. In an interview, E1 acknowledged a medical practitioner did not perform a medical history and physical examination or a registered nurse performed a nursing assessment on a resident within 30 calendar days before admission or within 72 hours after admission and documented the medical history and physical examination or nursing assessment in the resident's medical record within 72

		hours after admission, for R1, R3, and R4.
Findings for: Citation 10 **Corrected Date:** 02/23/2023	**Rule/Statute:** Admission; Assessment **Rule Text:** A. An administrator shall ensure that: 8. If a behavioral health assessment is conducted by a: a. Behavioral health technician or registered nurse, within 24 hours a behavioral health professional, certified or licensed to provide the behavioral health services needed by the resident, reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the resident; or	**Survey Text:** **R9-10-707.A.8.a~** Based on record review and interview, the administrator failed to ensure, a behavioral health assessment conducted by a behavioral health technician or registered nurse, was reviewed and signed by a behavioral health professional (BHP) within 24 hours, for two of six residents sampled. The deficient practice posed a risk as an analysis of the resident's needs for behavioral health services was not reviewed within 24 hours to ensure the behavioral health assessment identified the behavioral health services needed by the resident. Findings include: 1. A review of R1's medical record revealed a behavioral health assessment titled, "Initial Assessment," completed, signed, and dated by a behavioral health technician (BHT) in 2023. However, the assessment was not signed and dated by the facility's BHP until five(5) days after the BHT. 2. A review of R3's medical record revealed a behavioral health assessment titled, "Initial Assessment," completed, signed, and dated by a behavioral health technician in 2023. However, the assessment was not signed and dated by the facility's BHP until five(5) days after the BHT. 3. In an interview, E1 acknowledged the BHP did not review and sign the behavioral health assessment for R1 or R3 within 24 hours to ensure the behavioral health assessment identified the behavioral health services needed by the resident.
Findings for: Citation 11 **Corrected Date:** 02/23/2023	**Rule/Statute:** Resident Rights **Rule Text:** C. For a behavioral health residential facility with licensed capacity of less than 10 residents, if a behavioral health professional determines that a resident's treatment requires the behavioral health residential facility to restrict the resident's ability to participate in the activities in subsection (B)(3), the behavioral health professional shall: 1. Document a specific treatment purpose in the resident's medical record that justifies restricting the resident from the activity,	**Survey Text:** **R9-10-711.C.1~** Based on documentation review, record review, and interview, the administrator failed to ensure, if a behavioral health professional (BHP) determines that a resident's treatment requires the behavioral health facility to restrict the resident's ability to participate in the activities in subsection (B)(3), the behavioral health professional documented a specific treatment purpose in the resident's medical record that justified restricting the resident from the activity. The deficient practice posed a risk, as restricting a resident's phone calls is a violation of the resident's rights if no clinical indication specific to each individual is identified and documented. Findings include: 1. R9-10-711(B)(3) states, "3. Except as provided in subsection (C) or (D), and unless restricted

		by the resident ' s representative, a resident is allowed to: a. Associate with individuals of the resident ' s choice, receive visitors, and make telephone calls during the hours established by the behavioral health residential facility; b. Have privacy in correspondence, communication, visitation, financial affairs, and personal hygiene; and c. Unless restricted by a court order, send and receive uncensored and unopened mail." 2. A review of the facility's postings and policies and procedures revealed a document titled, "Policy Regarding Client Phone Calls." The document stated, "...clients are restricted from making or receiving phone calls to or from anyone other than their parents. Phone calls to parents will only be allowed at times which are not disruptive to the therapeutic process. In cases where a phone call is made to a client's parent, the counseling staff will place the call for the client, to ensure contact with individuals other than their parents is not made..." 3. A review of R1's medical record revealed no documentation of a specific treatment purpose, made by the BHP, that justified restricting R1's phone calls. 4. A review of R3's medical record revealed no documentation of a specific treatment purpose, made by the BHP, that justified restricting R3's phone calls. 5. A review of R4's medical record revealed no documentation of a specific treatment purpose, made by the BHP, that justified restricting R4's phone calls. 6. In an interview, R4 reported residents are not allowed to have any visitors except during one family counseling session when residents make amends to their families. R4 reported residents are not allowed to make phone calls to their parents but can send them a letter. 7. In an interview, E7 reported residents are only allowed to call parents on a special occasion, and if they do, the phone call is put on speaker and made in front of a staff person. 8. In an interview, E1 reported residents are allowed visitors on Thursday nights after their outpatient support group meeting, however, most residents' families live out of state and are unable to visit. E1 reported phone calls to parents are restricted to special occasions or in the case of an emergency. E1 reported phone calls are placed by staff who sit with the resident when making the call, but are not placed on speaker.

Findings for:	Rule/Statute:	Survey Text:
Citation 12 **Corrected Date:** 02/17/2023	Behavioral Health Services **Rule Text:** A. An administrator shall ensure that: 2. If a behavioral health residential facility is licensed to provide behavioral health services to individuals whose behavioral health issue limits the individuals' ability to function independently, a resident admitted to the behavioral health residential facility with limited ability to function independently receives: b. Continuous protective oversight;	**R9-10-716.A.2.b~** Based on documentation review, record review, and interview, the administrator failed to ensure, if a behavioral health residential facility was licensed to provide behavioral health services to individuals whose behavioral health issue limits the individuals' ability to function independently, a resident admitted to the behavioral health residential facility with limited ability to function independently received continuous protective oversight. The deficient practice posed a risk to R1, R2, R3,R4, R5, and R6 who required continuous protective oversight due to being minors under the age of 18. Findings: 1. A review of the facility's policies and procedures revealed a document titled, "Step Two Recovery Center's Scope of Services." The document stated, "Step Two Recovery Center (STRC) is an eight bed behavioral health residential facility designed for teenagers, ages 13 through 17, who are experiencing a behavioral health issue that limits the individual's ability to function independently or causes the individual to require treatment in order to maintain or enhance independence...This is achieved through the provision of a program which includes: a) group, individual, and family counseling; b) monitored attendance at twelve step support group meetings; c) supervised attendance at support-group sponsored sober social functions;...e) continuous protective oversight..." 2. A review of the facility's policies and procedures revealed a document titled, "Policy Regarding Routine Outings." The document stated, "For the purposes of this policy routine outings include: trips to the [outpatient treatment center] counseling center for group therapy, and trips to regularly scheduled support group meetings and social functions..." 3. In an interview, R1 and R2 reported residents are not allowed to smoke or vape at the facility. However, R1 and R2 reported to being allowed to smoke or vape while at the outpatient treatment center the residents go to four days per week, six hours per day. R1 and R2 reported if a resident wanted cigarettes, they would have to use their money out of their food allowance and ask an older patient at the outpatient treatment center to purchase cigarettes for them. R1 and R2 reported facility personnel are always with the residents and are aware when they

		are smoking or vaping. 4. In an interview, R3 reported residents are not allowed to smoke or vape at the facility, but they can smoke or vape outside at the outpatient treatment center if the older kids buy them cigarettes. R3 reported facility personnel are aware they are smoking or vaping. 5. In an interview, R4 reported residents can only smoke or vape outside at the outpatient treatment center if the older kids buy the residents cigarettes or vape products. R4 reported staff are aware the residents smoke and vape at the outpatient treatment center, as they often see the residents smoking or vaping. 6. In an interview, R6 reported the residents are allowed to smoke or vape, but not at the facility, and only at the outpatient treatment center. 7. In an interview, E1 reported the residents attend the outpatient treatment center four days per week from 10:00 AM - 4:00 PM. E1 acknowledged that per the facility's policy, this is considered an outing, and the resident's are required to have continuous protective oversight, as they are under 18. E1 acknowledged facility personnel are aware the residents smoke and vape at the outpatient treatment center, but reports the facility does not provide the residents with tobacco or nicotine products.
Findings for: Citation 13 **Corrected Date:** 02/17/2023	**Rule/Statute:** Behavioral Health Services **Rule Text:** A. An administrator shall ensure that: 5. Behavioral health services listed in the behavioral health residential facility's scope of services are provided on the premises;	**Survey Text:** **R9-10-716.A.5**~ Based on documentation review, record review, and interview, the administrator failed to ensure the behavioral health services listed in the behavioral health residential facility's scope of services were provided on the premises. The deficient practice posed if a risk a resident did not receive treatment to cure, improve, or palliate their behavioral health issue at the health care institution. Findings include: 1. A review of the facility's policies and procedures revealed a document titled, "Step Two Recovery Center's Scope of Services." The document stated, "...The scope of services provided by Step Two Recovery Center include a safe, supportive, twelve-step oriented living enviroment, in conjunction with substance abuse treatment. Treatment services are provided under contract by the [outpatient treatment center], a state licensed treatment program. The goal of Step Two recovery Center is to provide an environment which essentially supports the resident, the resident's family, and the treatment team in achieving treatment goals

related to the resident's integration into the recovering community. This is achieved through the provision of a program which includes: a.) group, individual, and family counseling; b.) monitored attendance at twelve-step support group meetings; c.) supervised attendance at support group-sponsored sober social functions; d.) provision of recovery coaching by personnel; e.) continuous protective oversight, transportation, housing and food; f.) assistance in the self-administration of medication; and e.) (sic) freedom from communication with and influence of drug abusing peers..." 2. A review of R1's medical record revealed a document titled, "STRC Treatment Plan," dated January 5, 2023. The document stated R1 would receive the following services: "...Group treatment 5 x weekly for 6 hours per day; individual appointments 1 x weekly; Parents contacted 1 x weekly; (4) 12 step meetings weekly; (2) sober social functions weekly..." The document was signed by the resident, "STRC personnel," and the BHP on January 5, 2023, and by the resident's legal guardian on February 9, 2023. 3. A review of R1's medical record revealed documents titled, "Progress Note," which documented group counseling completed for R1 on the following dates and times: -January 19, 2023, from 12:00 PM - 4:00 PM; -January 26, 2023, from 12:00 PM - 4:00 PM; -February 2, 2023, from 12:00 PM - 4:00 PM; -February 9, 2023, from 10:00 AM - 4:00 PM 4. A review of R1's medical record revealed a document titled, "Individual Note," dated February 2, 2023, which documented an individual counseling session for R1 completed on that date. 5. A review of R3's medical record revealed a document titled, "STRC Treatment Plan," dated February 8, 2023. The document stated R3 would receive the following services: "...Group treatment 5 x weekly for 6 hours per day; individual appointments 1 x weekly; Parents contacted 1 x weekly; (4) 12 step meetings weekly; (2) sober social functions weekly..." The document was signed by the resident, "STRC personnel," and the BHP on February 9, 2023, and by the resident's legal guardian on February 16, 2023. 6. A review of R3's medical record revealed documents titled, "Progress Note," which documented group counseling completed for R3 on the following dates and times: -February 9, 2023, from 10:00 AM - 4:00 PM 7. A review of R4's

		medical record revealed a document titled, "STRC Treatment Plan," dated February 6, 2023. The document stated R4 would receive the following services: "...Group treatment 5 x weekly for 6 hours per day; individual appointments 1 x weekly; Parents contacted 1 x weekly; (4) 12 step meetings weekly; (2) sober social functions weekly..." The document was signed by the resident and "STRC personnel" on February 6, 2023, and by the BHP on February 9, 2023. The document did not contain a signature of R4's legal guardian. 8. In an interview, R1 and R2 reported residents got to the outpatient treatment center on weekdays for groups, then go to AA meetings. R1 and R2 reported on weekends the residents go to functions with the group at the outpatient treatment center. 9. In an interview, R3 reported going to the outpatient treatment center on the weekdays for groups. 10. In an interview, R4 reported residents go the the outpatient treatment center most weekdays for groups and get individual counseling either at the outpatient treatment center or at the facility by Step Two personnel or the outpatient treatment center staff. 11. In an interview, R5 reported residents go to the outpatient treatment center four days per week for groups. R5 reported on Thursdays the residents stay at the facility and do "couch patient," or "outpatient on the couch." R5 reported E9 comes to the facility to run groups and do individual treatment plans with residents. 12. In an interview, R6 reported residents go to the outpatient treatment center four days per week for groups and Thursdays are "off" days. 13. In an interview, E1 reported none of the residents' counseling session notes were on-site in their medical records at the facility. E1 requested E3 to bring the counseling session notes for all residents sampled to the facility from the outpatient treatment center for review by the Compliance Officers. 14. In an interview, E3 reported residents at Step Two go to the outpatient treatment center for group counseling on Mondays, Tuesdays, Wednesdays, and Fridays from 10:00 AM - 4:00 PM. 15. In an interview, E1 reported group and individual counseling is done at the facility only on Thursdays.
Findings for: Citation 14 **Corrected Date:**	**Rule/Statute:** Behavioral Health Services **Rule Text:**	**Survey Text:** **R9-10-716.A.7.a~** Based on record review and interview, the

02/17/2023	A. An administrator shall ensure that: 7. A resident does not: a. Use or have access to any materials, furnishings, or equipment or participate in any activity or treatment that may present a threat to the resident's health or safety based on the resident's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, or personal history; or	administrator failed to ensure a resident did not use or have access to any materials, or participate in any activity or treatment that may present a threat to the resident's health or safety based on the resident's developmental levels. The deficient practice posed a risk as the residents were minors and had access to tobacco and nicotine products. Findings include: 1. A review of R1's, R2's, R3's, R4's, R5's, and R6's medical records revealed R1, R2, R3, R4, R5, and R6 were under the age of 18 years old. 2. In an interview, R1 and R2 reported residents are not allowed to smoke or vape at the facility. However, R1 and R2 reported to being allowed to smoke or vape while at the outpatient treatment center the residents go to four days per week, six hours per day. R1 and R2 reported if a resident wanted cigarettes, they would have to use their money out of their food allowance and ask an older patient at the outpatient treatment center to purchase cigarettes for them. R1 and R2 reported facility personnel are always with the residents and are aware when they are smoking or vaping. 3. In an interview, R3 reported residents are not allowed to smoke or vape at the facility, but they can smoke or vape outside at the outpatient treatment center if the older kids buy them cigarettes. R3 reported facility personnel are aware they are smoking or vaping. 4. In an interview, R4 reported residents can only smoke or vape outside at the outpatient treatment center if the older kids buy the residents cigarettes or vape products. R4 reported staff are aware the residents smoke and vape at the outpatient treatment center, as they often see the residents smoking or vaping. 5. In an interview, R6 reported the residents are allowed to smoke or vape, but not at the facility and only at the outpatient treatment center. 6. In an interview, E1 acknowledged the residents are minors and the facility's personnel is aware of the residents smoking and vaping at the outpatient treatment center. E1 acknowledged the residents have access to materials and participate in activities or treatment that may present a threat to the resident's health or safety.
Findings for: Citation 15 **Corrected Date:** 02/20/2023	**Rule/Statute:** Medication Services **Rule Text:** C. If a behavioral health residential facility provides assistance in the self-administration of medication, an	**Survey Text:** **R9-10-718.C.6.a~** Based on record review and interview, the administrator failed to ensure assistance in the self-administration of medication provided

	administrator shall ensure that: 6. Assistance in the self-administration of medication provided to a resident: a. Is in compliance with an order, and	to a resident was in compliance with an order, for two of six residents sampled. Findings include: 1. A review of R1's medical record revealed a medication administration record (MAR) titled, "Medication Form." The document indicated R1 was provided assistance in the self-administration of "Spironolactone 50mg," twenty-seven times in January and February 2023, and "Doxycycle 50mg," twenty-three times in January and February 2023. 2. A review of R1's medical record revealed a document titled, "Step Two Recovery Center Physician Orders," dated January 6, 2023. The document listed the following medications: -"Acetaminophen 500mg by mouth every 6 hours as needed...;" -"Ibuprofen 200mg by mouth every 6 hours as needed...;" The document was signed and dated on January 6, 2023, by E1. The document was not signed by a medical practitioner. Medication orders for "Spironolactone 50mg,"and, "Doxycycle 50mg,"were not available for review. 3. A review of R3's medical record revealed a medication administration record (MAR), titled, "Medication Form." The document indicated R3 was provided assistance in the self-administration of "Cetirizine Hydrochloride 10mg" at 12:20 PM on February 12, 2023. 4. A review of R3's medical record revealed a document titled, "Step Two Recovery Center Physician Orders," dated February 10, 2023. The document listed the following medications: -"Acetaminophen 500mg by mouth every 6 hours as needed...;" -"Ibuprofen 200mg by mouth every 6 hours as needed...;" -"Cetirizine Hydrochloride - 10 mg as needed for allergies" The document was signed and dated on February 12, 2023, by E1. The document was not signed by a medical practitioner. 5. In an interview, E1 reported R1's and R3's medication orders were verbal orders taken by E1 from E5, the facility's medical practitioner. E1 acknowledged R1 and R3 were not provided assistance in the self-administration of medication in compliance with an order.
Findings for: Citation 16 **Corrected Date:** 02/17/2023	**Rule/Statute:** Medication Services **Rule Text:** E. When medication is stored at a behavioral health residential facility, an administrator shall ensure that: 1. Medication is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication	**Survey Text:** **R9-10-718.E.1~** Based on observation and interview, the administrator failed to ensure medication was stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage. The deficient practice

	storage;	posed a risk to the physical health and safety of a resident. Findings include: 1. During a facility tour, the Compliance Officers observed the following medications prescribed to R1 in an unlocked cabinet in R1's bathroom: -"Trentinoin 0.025% Cream; Apply a pea sized amount to face. Start 3 nights per week then increase to use nightly as tolerated..;" -"Pimecrolimus Cream 1%; For topical use only; Rx only..." 2. In an interview, E1 acknowledged the medication was not stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage.
Findings for: Citation 17 **Corrected Date:** 02/17/2024	**Rule/Statute:** Physical Plant Standards **Rule Text:** B. An administrator shall ensure that: 1. A behavioral health residential facility has a: a. Room that provides privacy for a resident to receive treatment or visitors; and	**Survey Text:** **R9-10-722.B.1.a**~ Based on observation and interview, the administrator failed to ensure the behavioral health residential facility had a room that provided privacy for a resident to receive treatment or visitors. The deficient practice posed a risk if the administrator was unable to ensure confidentiality in treatment as well as a resident's right for privacy in treatment and visitation. Findings include: 1. During a tour of the facility the Compliance Officers observed no room that provided privacy for a resident to receive treatment or visitors. 2. During a facility tour, the Compliance Officers observed E9 provided counseling to a resident on the steps of the facility's outside back porch. 3. In an interview, E7 reported the facility did not have a room that provided privacy for a resident to receive treatment or visitors. E7 reported that counseling was completed on the facility's outside back porch. 4. In an interview, E1 reported the facility did not have a room that provided privacy for a resident to receive treatment or visitors, and that going forward, the facility will use the office space as a room to provide privacy for a resident to receive treatment or visitors.
Findings for: Citation 18 **Corrected Date:** 02/22/2023	**Rule/Statute:** Physical Plant Standards **Rule Text:** B. An administrator shall ensure that: 8. A resident bedroom complies with the following: k. Has a clothing rod or hook in the bedroom designed to minimize the opportunity for a resident to cause self-injury.	**Survey Text:** **R9-10-722.B.8.k**~ Based on observation and interview, the administrator failed to ensure a resident bedroom had a clothing rod or hook in the bedroom designed to minimize the opportunity for a resident to cause self-injury. The deficient practice posed a risk to the physical health and safety of a resident. Findings include: 1. During a facility tour, the Compliance Officers observed five resident bedrooms that contained a closet with metal

		bracket support hooks holding up light-weight PVC pipe being used as a closet rod. The support hooks did not give way when the Compliance Officers pulled on them in a downward motion. 2. In an interview, E1 acknowledged the support hooks were not designed to minimize the opportunity for a resident to cause self-injury.
Findings for: Citation 19 **Corrected Date:** 02/20/2023	**Rule/Statute:** Behavioral Health Paraprofessionals; BHTs **Rule Text:** R9-10-115. Behavioral Health Paraprofessionals; Behavioral Health Technicians If a health care institution is a behavioral health facility or is authorized by the Department to provide behavioral health services, an administrator shall ensure that: 4. A behavioral health technician receives clinical oversight at least once during each two week period, if the behavioral health technician provides services related to patient care at the health care institution during the two week period;	**Survey Text:** **R9-10-115.4~** Based on documentation review, record review, and interview, the administrator failed to ensure a behavioral health technician (BHT) received clinical oversight at least once during each two week period if the BHT provided services related to patient care at the health care institution during the two week period. The deficient practice posed a potential risk if staff were not properly supervised by a behavioral health professional (BHP). Findings include: 1. A review of the facility's policies and procedures revealed a policy titled, "Policy Regarding Clinical Oversight." The document stated, "...Behavioral Health Technicians who are required to receive clinical oversight must receive 4 hours monthly..." 2. A review of E7's personnel record revealed E7 was hired as a behavioral health technician (BHT) in 2019. 3. A review of E7's personnel record revealed a document titled, "Team Clinical Oversight Summary." The document indicated two hours of clinical oversight was completed on the following dates: -January 31, 2023; -December 27, 2022; -December 6, 2022; -November 29, 2022; -November 1, 2022; -August 30, 2022; -July 26, 2022; -July 17, 2022; -June 23, 2022; -May 3, 2022; -February 22, 2022; 4. A review of E7's personnel record revealed a documents titled, "Individual Clinical Oversight." The documents indicated clinical oversight was provided on the following dates and duration: -January 30, 2023 for 1 hour; -November 2, 2022 for 1 hour; -August 15, 2022 for 2 hours; -August 8, 2022 for 1 hour; -June 24, 2022 for 2 hours; -May 20, 2022 for 2 hours; -May 6, 2022 for 2 hours; -April 22, 2022 for 2 hours; -April 8, 2022 for 2 hours; -March 31, 2022 for 1 hour; -March 24, 2022 for 1 hour; -March 17, 2022 for 1 hour; -March 3, 2022 for 1 hour -February 17, 2022 for 1 hour; -February 10, 2022 for 2 hours 5. In an interview, E1 acknowledged E7 was a behavioral health technician who required

		clinical oversight. E1 acknowledged E7 was not provided clinical oversight per the requirements in R9-10-115.