Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL088-020	A. BUILDING: ______ B. WING ______	R 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAILS CAROLINA	500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747

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V 000	INITIAL COMMENTS An annual, complaint, and follow up survey was completed on March 21, 2024. The complaints were substantiated (NC#00212904 & NC#00212978). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5200 Residential Treatment Camps for Children and Adolescents of all Disability Groups. This facility is licensed for 108 and currently has a census of 20. The survey sample consisted of audits of 10 current clients, 9 former clients, and 1 deceased client.	V 000	10A NCAC 27G .0209 Medication Requirements (V118) Each client will be required to arrive with signed physician's orders. Qualifying documents include: Signed prescription copies, a physician's signed letter, physician's signed OTC form, a prescription copy including a digital signature accompanied by an individual prescription number, and including the physician's DEA and NPI numbers, and digital signatures provided by the Trails consulting psychiatrist via their individual EHR/BestNotes LogIn.	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug;	V 118	Enrollment paperwork will be updated to include mandatory consent documents for the Trails consulting psychiatrist completed prior to the client's admission, stating that the client's family agrees to a mandatory appointment with Trails consulting psychiatrist and agrees to the additional fees associated with the consultation, in case they fail to provide one of the above approved documents, fail to provide appropriate medication supply during the client's stay, or if the client had a medication adjustment request and the home	

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V 118	Continued From page 1 (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to ensure that medications were administered on the written order of a physician affecting 8 of 10 audited current Clients (#2-6, #8, #9 and #11), 8 of 9 audited Former Clients (FC #14-21) and 1 of 1 audited Deceased Client (DC #1) and failed to keep MARs current for 8 of 10 audited current Clients (#2-6, #8, #9 and #11) and 8 of 9 audited Former Clients (FC #14-21). The findings are: Review on 2/7/24 of DC #1's record revealed:	V 118	provider is unavailable for a telehealth appointment. Leading up to enrollment, Admissions will notify the client's family of any needed documentation. Should the client arrive without appropriate medication approval, admissions will follow up with the family the same day. If the client arrives without prescriptions and the family is unable to provide the needed documentation, an appointment will be scheduled with the Trails consulting psychiatrist, to take place within 48 hours. Physician's orders will be followed as written. Any medication adjustment requests or reported side effects will be recorded on the MAR and followed up with the client's family and a physician. Physician's orders will be reviewed at the client's enrollment by Admissions and/or Health and Wellness. Prescriptions will be reviewed by the Health and Wellness team weekly along with the client's MAR from the previous shift. All MARs will be kept current and include the client's name, medication name, strength, and quantity of the drug;	

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V 118	Continued From page 2 Review on 2/9/24 of DC #1's MAR dated revealed: -1 dose of was initialed by DC #1 and Lead Staff #1 as having been administered. Review on 2/9/24 of the Trails Carolina Medication Count Log for DC #1 dated revealed: -Medications initialed as received by Lead Staff #1 included: Review on 2/28/24 of the local hospital "Chain of Custody/Evidence Release Form" and "Medication Log" for DC #1 signed by the local pathologist dated 2/9/24 revealed: -Items of evidence included: Review on 2/22/24 and 2/29/24 of Client #2's record revealed: -No physicians' orders. Review on 2/29/24 of Client #2's MARs dated revealed: -The following medications were initialed as administered:	V 118	instructions for administering the drug, date and time the drug is administered, and the name or initials of the person administering. Each MAR will be dated correctly for the associated week. Staff will include the medication name, strength, and quantity of the drug; instructions for administering the drug, date and time the drug is administered, and the name or initials of the person administering, and the reason for administering the drug, for all approved Over the Counter medications and prescribed PRN (as needed) medications. Training will be provided by Health and Wellness staff (quarterly and when review is needed), and Consulting Physician's office (quarterly) on all the necessary information to include on the MAR. All MARs will be reviewed by Health and Wellness staff along with the Lead staff at the end of each shift to make sure all necessary information has been included. All Missed and Refused medications will be required to be clearly labeled on the Client's MAR as "Missed" and "Refused". There will be corresponding Incident Report (IR) and Pharmacy	

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V 118	Continued From page 3 Review on 2/22/24 and 2/29/24 of Client #3's record revealed: -No physicians' orders. Review on 2/29/24 of Client #3's MARs dated revealed: -The following medications were initialed as administered:	V 118	Notification/Recommendation Forms. The IR will include details on how the error occurred and the follow-up action taken. The MAR will reflect the pharmacy recommendations received and followed. Requiring the completion of consent documentation for Trails consulting psychiatrist at the client's enrollment will lessen any previous supply issues. Should the family not respond to medication refill requests within 7 days of a medication being needed, an appointment will be made with Trails consulting psychiatrist to prevent a lapse in the client's medication schedule. Staff will continue to report all medication errors at the time of the incident. A pharmacist will be contacted for recommendations on how to move forward; recommendations will be followed by the lead staff and reflected on the client's MAR. Medication Errors are reviewed by Health and Wellness on Wednesday, at the end of each shift. All medication errors/IRs are also reviewed by the leadership team weekly during the Operations Meeting. *Please note that our creation of a POC for this citation does not indicate full agreement with conclusions of the state report and discrepancies will be addressed at the scheduled informal	

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V 118	Continued From page 4 Review on 2/22/24 and 2/29/24 of Client #4's record revealed: -No physicians' orders. Review on 2/29/24 of Client #4's MAR dated revealed: -1 dose of was initialed as administered on with no documentation of the strength, quantity, or frequency of the medication. Review on 2/22/24 and 2/29/24 of Client #5's record revealed: -No physicians' orders. Review on 2/29/24 of Client #5's MAR dated revealed:	V 118	conference on April 23 at 1pm. For example: a) The medication counts presented by the local pathologist on 2/9/24, regarding does NOT match the counts or conversations had on 2/3/24 with Trails staff, local law enforcement and onsite M.E. b) The claims referring to the documentation system for students missing medications due to lack of or slow parent, home physician, insurance company or pharmacy response was developed collaboratively with and signed off on by state surveyors in 2019 and adhered to. Which the state is now claiming is inadequate.	

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V 118	Continued From page 5 -The following medications were initialed as administered: with instructions to "Please record the dose." The number of tablets administered was not documented for any of the doses. -No MARs were provided for or Review on 2/14/24 and 2/29/24 of Client #6's record revealed: Review on 2/29/24 of Client #6's MARs dated revealed: MAR had typed instructions for Take only at	V 118		

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V 118	Continued From page 6 was handwritten beside it. No documentation of being administered from MARs had typed instructions for when at only. No documentation of being administered -No MAR was provided for Review on 2/14/24 and 2/29/24 of Client #8's record revealed: -Physician's Progress Note dated " ...Current Outpatient Medications: -No physician's orders for any of the outpatient medications listed on the Progress Note and no instructions were documented for the quantity, or frequency of the	V 118		

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V 118	Continued From page 7 Review on 2/29/24 of Client #8's MARs dated [redacted] revealed: -The following medications were initialed as administered: -1 dose of [redacted] with no documentation of the strength, quantity, time, or instructions for administering the medication. -31 doses of [redacted] twice daily PRN (instead of scheduled) with no instructions for the reason to administer the medication. [redacted] [redacted] was not initialed as administered for [redacted] -No MARs were provided for [redacted] through the date of discharge. Review on 2/14/24 and 2/29/24 of Client #9's record revealed: [redacted] -No physician's orders from [redacted] Review on 2/29/24 of Client #9's MARs dated [redacted] revealed: -MAR was dated [redacted] but had 8 days of documented medication administration.	V 118		

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V 118	Continued From page 8 -The following medications were initialed as administered -There was no MAR provided for through the date of discharge. Review on 2/14/24 and 2/29/24 of Client #11's record revealed: Review on 2/29/24 of Client #11's MARs dated revealed: was initialed as administered twice (instead of once) on	V 118		

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V 118	Continued From page 9 was initialed as administered three times (instead of twice) on was not initialed as administered on or was not initialed as administered on -4 doses of and 1 dose of was initialed as administered with no documentation of the strength, quantity, or instructions for administering the medication. -4 doses of 3 doses of and 2 doses of were initialed as administered with no documentation of the strength, quantity, time, or instructions for administering the medication. -No MARs for Review on 2/29/24 and 3/12/24 of FC #14's record revealed:	V 118		

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V 118	Continued From page 10 Review on 2/29/24 of FC #14's MARs dated revealed: -Typed instructions for every evening PRN (instead of scheduled) 14 doses were initialed as administered with no documentation of the quantity. -1 dose of with no documentation of the strength, quantity, time, or instructions for administering the medication. -The following medications were initialed as	V 118		

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V 118	Continued From page 11 administered without a signed physician's order: -No MAR for Review on 2/29/24 and 3/12/24 of FC #15's record revealed:	V 118		

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V 118	Continued From page 12 Review on 2/29/24 of FC #15's MARs dated revealed: -5 doses of were initialed as administered with no documentation of the time, quantity, or frequency. -5 doses of were initialed as administered with no documentation of the quantity, or time it was received. -1 dose of and 2 doses of were initialed as administered with no documentation of the strength, quantity, time, or instructions for administering the medication. -12 doses of and 6 doses of were initialed as administered over a period of 6 days on an undated MAR. was handwritten on the MAR with no documentation of the quantity, or instructions for administering the medication; was handwritten on the MARs with no documentation of the quantity, or instructions for administering the medication. was initialed as administered over a period of 18 days instead of 14 days and only 49 of 56 doses were documented as follows: 1 dose at 8:00 pm. 1 dose at 8:00 am, 2:00 pm and 8:00 pm. 2 doses at 2:00 pm. No other doses were initialed as administered. 1 dose at 8:00 am, 2:00 pm and 8:00 pm. no doses were initialed as administered. A capital letter M was handwritten	V 118		

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V 118	Continued From page 13 in each dosing space with a circle drawn around each letter with no explanation of the meaning. [redacted] 1 dose at 8:00 am, 2:00 pm and 8:00 pm. [redacted] 1 dose at 8:00 am. Review on 2/27/24 and 2/29/24 of FC #16's record revealed: [redacted] -Handwritten note "ok to use [redacted]" with no documented instructions. Review on 2/29/24 of FC #16's MARs dated [redacted] revealed: -No MARs for the weeks of [redacted] [redacted]	V 118		

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V 118	Continued From page 14 -No documentation of being administered on or -No documentation of being administered in the morning on or -No documentation of being administered in the evening on or was typed onto each of the MARs with no documentation of the strength, quantity, frequency, or instructions for administering the medication. 1 dose was initialed as administered on -6 doses of 1 dose of 1 dose of and 1 dose of were initialed as administered with no documentation of the strength, quantity, frequency, or instructions for administering the medication. -21 doses of and 3 doses of were initialed as administered with no documentation of the time, strength, quantity, frequency, or instructions for administering the medication. Review on 2/29/24 and 3/12/24 of FC #17's record revealed:	V 118		

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V 118	Continued From page 15	V 118		

Review on 3/19/24 of an email dated 3/19/24 received from the Director of Operations to the Division of Health Service Regulation (DHSR) surveyors revealed:
-Diagnoses by history for FC #17:

Review on 2/29/24 of FC #17's MARs dated revealed:
was not initialed as administered on due to "lack of supply."
was documented as (instead of with 29 doses initialed as administered.
-27 doses of were initialed as administered without time, quantity, or physician order.
-22 doses of were initialed as administered without time, quantity, or

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V 118	Continued From page 16 instructions for administration. -7 doses of [redacted] were initialed as administered without documentation of quantity and 5 of the doses had no time. Review on 2/27/24 and 2/29/24 of FC #18's record revealed: [redacted] Review on 2/27/24 of FC #18's MARs dated [redacted] revealed: -29 doses of [redacted] were initialed as administered without time, instructions for administering the medication, or a physician's order. [redacted] was documented as PRN [redacted] (instead of scheduled daily) and was not initialed as administered from	V 118		

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V 118	Continued From page 17 -1 dose of was initialed as administered on with no documentation of time, quantity, or instructions for administering the medication. -1 dose of was initialed as administered on with no documentation of time, quantity, or instructions for administering the medication. -1 dose of was initialed as administered on with no documentation of strength, quantity, or time of the medication. Review on 2/29/24 of FC #19's record revealed:	V 118		

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-Physician's order dated included to [local pharmacy]" with no documentation of the strength, quantity, or instructions for administering the medication.
-A label from a local pharmacy dated for 14 capsules (7-day supply) of had no instructions for administering the medication.
-No physician's order for or an

Review on 2/29/24 of FC #19's MARs dated revealed:
-Typed instructions for daily in the morning Monday-Friday only. Initialed as administered only Monday-Friday (instead of daily) for 8 weeks except for Saturday

-7 doses of PRN every 6 hours were initialed as administered with no documentation of the quantity, or time it was received.
- 14 doses of 1 dose of and 2 doses of were initialed as administered with no documentation of the strength, quantity, time, or instructions for administering the medication.
-3 doses of 2 doses of 1 dose of and 1 dose of were initialed as administered with no documentation of the strength, quantity, or instructions for administering the medication.
-55 doses of daily in the morning were initialed as administered.

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with no other instructions was handwritten on the MAR; was handwritten on the and MARs with no instruction for the reason to administer the medication; was handwritten on the MAR with no documentation of the strength, or reason to administer the medication; was handwritten on the MAR with no other instructions.

Review on 2/29/24 of FC #20's record revealed:
-Date of Admission: Not provided

-Age: Not provided
-Diagnoses: Not provided
-No physician orders.

Review on 3/19/24 of an email dated 3/19/24 received from the Director of Operations to the Division of Health Service Regulation (DHSR) surveyors revealed:

Review on 2/27/24 of FC #20's MAR dated revealed:
-The following medications were initialed as administered:

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V 118	Continued From page 20 -7 doses of were initialed as administered with no documentation of the strength, or time. -7 doses of were initialed as administered with no documentation of the strength, quantity, time, or instructions for administration. -No MARs were provided from Review on 2/27/24 of FC #21's record revealed: Review on 2/27/24 of FC #21's MARs dated revealed: -2 doses of were initialed as administered on and with no documentation of the time, dosage, quantity, or instructions for administration. -7 doses of were initialed as administered daily with documentation of the quantity, dosage, or instructions for administration. was not initialed as	V 118		

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administered on

-No MARs were provided from

Review on 2/6/24 of Facility Incident Reports dated revealed:

-13 missed dosages of medications due to "lack of supply" involving 8 clients as follows:

-Client #8:

-Client #9:

-FC #14:

-FC #16:

-FC #17:

-FC #18:

-FC #20:

-FC #21:

Review on 2/13/24 of an email dated 2/13/24 received from the Health and Wellness Director to DHSR surveyors revealed:

-"I am going to offer a narrative in an effort to provide context, although I realize little consideration is given to the background. Upon admission [Client #6's] mother reported that [Client #6] had not been taking his for quite some time, and that she would like us to offer this medication as needed. The physician's signed OTC (over the counter) document did not match the received order. We initially defaulted to the order, as is appropriate. However, the student reported side effects and was resistant to taking the medication even, on one occasion, 'cheeking' and hiding the capsule (see IR (incident report) previously provided). We followed up with the parents who put in writing (see BN (Best Notes))

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to please offer the medication as needed, and that they would send us the corrected order. When the order was received, it still stated daily. We followed up with the family and the prescriber on multiple occasions, receiving no response. The family has now agreed to an appointment with our consulting psychiatrist, which is currently scheduled for [redacted] and we are seeking an earlier appointment to rectify our records as quickly as possible. While I do understand the errors that were made, I also think it is important to consider the timeline of events."

Interview on 2/6/24 with Lead Staff #2 revealed:
-"From time to time (have issues with not having enough medications). That's why you count, notify health and wellness. They would call the pharmacy."

Interview on 2/8/24 with the local Medical Examiner revealed:
-Reviewed the medication bottles and drug count for DC #1.
-DC #1 was prescribed [redacted]
-Two bottles of [redacted] were both filled on [redacted]
-The medication count of [redacted] "was off."

Interview on 2/9/24 with the Admissions Director revealed:
-Trails Carolina had their own process for medications during admissions/intake.
-Medications were received by "whomever" is doing the intake.
-Staff documented the number of medications received.

Interview on 2/12/24 and 2/27/24 with the Health and Wellness Director revealed:

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V 118	Continued From page 23 -Responsibilities included making sure required documentation was completed upon admission, tracking medications, communicating with prescribers and parents, and coordinating physician orders with the local pharmacy. -"I am a wilderness EMT (Emergency Medical Technician) for this role. My background does not have much to do with this role. I am a wilderness therapy kid (client) and came back to do this role." -There were only two Health and Wellness staff at the facility. -"Nothing is streamlined because of our transitional model ...We have a lot of records." -The facility had a consulting physician and psychiatrist. -The consulting physician would come in quarterly to provide training. -If a client's home psychiatrist was willing to continue to see the client, the facility would work with them. -Lack of medications supply (on incident reports) "could be a variety of issues." -"Some parents send us meds (medications). We encourage them to use our local pharmacy. We wait for them to send it." -"A few times where prescriber hasn't sent in medication. And we work with family and prescriber to make sure we get that." -"We try to take care of it (medication supply) independently. If we have to communicate with the prescriber, the parents help that." -Medication errors from the previous week were discussed every Monday during the operations meeting which included managers from all departments and the Executive Director. -A 30-day supply of medication would be requested at admission. -"Yes. Feel that is the case (medication supply issues) since I have been here."	V 118		

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-MARs were created from the medications sent at admission and created on the client's first day at the facility.
-Second audits were done by a different staff member.
-If staff offered an OTC medication, it would be signed on the MAR.
-[redacted]
-"We review them (MARs) against records when they first come in and anytime they are updated, or doing an audit ...not a set schedule."
- When reviewing medication documentation " ...making sure prescriptions match the order we have on file ...make sure all signatures are there."
-Reviewed MARs when staff and clients came out of the field every week.
-If there was a discrepancy between MARs and orders, the facility would follow the doctor's orders.
-"We are going by doctor's orders and pushing parents to go in line with doctors requests."
-" ...admittedly they (staff) are not doing that (putting dosage on the MAR) and following dosage on packaging."
-It was a team effort to make sure clients received medications as ordered.
-" ...working with my team to make sure they (medications) are refilled appropriately and communicate with family for those needs. And when I struggle, I communicate with the greater team. I discuss on Monday and then on Friday with treatment team."
-"Trails is the team. Everyone is responsible."
-"...our biggest issue is helping families in crisis. So, the kids (clients) are coming in fast. So, trying to get information on the front end. Wish that could be better. In a perfect world we would have all scripts (prescriptions) in hand prior to a kid arriving. I think we do the best with what we have."

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Interview on 2/9/24 with the Operations Director revealed:
-Health and Wellness staff prepared clients' medication upon admission.
-The Health and Wellness team had not entered MARs and Medication Incident Reports into the system yet.

Observation on 2/12/24 at 1:49 pm of the Health and Wellness Medication locked storage room revealed:
-4 large stacks of numerous loose paper MARs which had been completed and not filed.

Interview on 2/21/24 with the Executive Director (ED) revealed:
-Couldn't speak specifically to medication errors related to the lack of supply.
-"Sometimes insurance, or parents have been uncooperative ...trying to get the outside source (for medications) is difficult."
-"It is not uncommon for us to have that issue."
-Asked that clients come with a 30-day supply of medication and a prescription. " ...doesn't always happen that way ...That is what we are asking for ..."
-"We will hold (medications) if we don't have hard scripts (prescription)."
-"Strangely not uncommon for parents to be unresponsive to emails or phone calls."
-Health and Wellness staff used to review medication errors during the operations call on Mondays.

Interview on 2/21/24 with the Founder/Executive Director revealed:
-"Been doing well with those (medication errors) for the last few years."
-"Usually across the board when the parent isn't

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getting (prescriptions) ...they want to use their pharmacy. The parents don't care, or understand. "
-"Best way is to allow our pharmacy to fill. And then from there. Med (medication) coordinators are calling parents a month ahead and that would be documented. Something we put a lot of time and energy into over the years."
-"Never been a problem (clients receiving the wrong medications). That would be a fire-able offense."

Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.

Review on 3/1/24 of a Plan of Protection dated 3/1/24 completed and submitted by the Executive Director revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
Our team will review medication administration P&P's (policies and procedures), including orders tracking, challenges with parental & professional communications regarding acquisition of medications in a timely fashion, tracking of OTC administration , and systematic checks and balances. Upon review we will determine adaptations to improve consistent & accurate medication administration. As of February 15th (2024) no students are enrolled in Trails.
Describe your plans to make sure the above happens.
We will set deadlines for action, assign specific individuals to tasks & changes, & have weekly checks and balances with leadership team reporting to ensure follow through."

Clients served by the facility ranged in age from

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V 118	Continued From page 27 10 to 18 years old. They had diagnoses including but not limited to Major Depressive D/O, ADHD, PTSD, Parent-Child Relational Problem, Generalized Anxiety D/O, Autism Spectrum Disorder, and Disruptive Mood Dysregulation Disorder. Clients were administered medications . Numerous medications were administered to clients without physician orders and other medications were not administered as prescribed. MARs were not documented accurately to reflect the strength, quantity, frequency, and/or instructions to administer the medications. There were 13 incident reports over a 3 month period which had medications documented as missed, or late due to lack of supply. Not all MARs matched the incident reports and indicated the medications had been administered. Multiple MARs were not provided for review as requested. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118	V 364 General Statute 122C-62 Additional Rights in 24-Hour Facilities The 122C-62. Additional rights in 24-hour facilities general statute states minor client have the rights to: Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; Trails will update the Authorization and Consent form language to state minor clients will have the ability to send and receive mail to parent/guardians without review. * It must be noted here this is against clinical recommendation as it could potentially provide harm to students to receive mail that has not been reviewed for the very reasons stated in the General Statute 122C-62. It states: "Additional rights in 24-hour facilities General Statute each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable	
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense	V 364		

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V 364	Continued From page 28 and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity	V 364	him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part." Trails therapists review incoming mail to ensure it is developmentally appropriate and written in a strengths-based approach to promote change, growth and treatment goals for the minor client. The lack of a trained mental health clinician present upon receipt of letters to provide developmentally, emotionally, and intellectually appropriate therapy to parents and child will become significantly challenged and cause possible harm to the minor client. Trails therapists review outgoing student mail to support students with communicating emotionally challenging topics, needs or requests to parents. No changes are made to aforementioned mail without student or parent consent, respectively, and by the student or parent. Students are able to write letters daily and have access to paper and writing	

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V 364	Continued From page 29 to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10) Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise.	V 364	utensils and an adult to provide accommodations as needed. Trails will update the Family Services Handbook form to state minor clients have the ability to have family therapy sessions through video calls or phone calls, as has been the practice of Trails in previous years. Client phone call requests and respective documentation will be discussed twice weekly during clinical supervision and treatment team meetings. Noted and monitored by the clinical director on meeting notes. *Please note that our creation of a POC for this citation does not indicate full agreement with conclusions of the state report and discrepancies will be addressed at the scheduled informal conference on April 23 at 1pm.	

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V 364	Continued From page 30 Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use	V 364	122C-62. Additional rights in 24-hour facilities General Statute states minor clients will have the right to “ Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; This General Statute does NOT state these calls need to be confidential. Trails therapists facilitate calls as minor clients enrolled at Trails have a number of special needs, including but not limited to diagnosis, intellectual and developmental needs, mental health needs, technological needs and the reason for being at Trails is to receive mental health services. The calls are family therapy sessions and require a trained mental health clinician to provide the therapy services. Should students request calls to parents, the requests will be considered by the primary therapist and parents. If a call is not granted, therapists will document the therapeutic reason why and revisit the request within the allotted time stated by state regulations.	

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V 364	Continued From page 31 personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the	V 364	*Please note that our creation of a POC for this citation does not indicate full agreement with conclusions of the state report and discrepancies will be addressed at the scheduled informal conference on April 23 at 1pm.	

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reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure that each minor client retained the right to communicate and consult with his parents or guardians and make and receive telephone calls. The findings are:

Review on 2/7/24 of Deceased Client #1's (DC #1) record revealed:

Review on 2/22/24 of Client #2's record revealed:

Review on 2/22/24 of Client #5's record revealed:

Review on 2/22/24 of Client #7's record revealed:

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Review on 2/9/24 of Former Client (FC) #22's record revealed:

Review on 2/22/24 of the facility's "Parent Authorization & Consent" form revealed:
- "In as much as I have enrolled my son/daughter (full name) ____ in the Trails Carolina Adolescent Program beginning on (date) ____ ...and realizing the Trails has exclusive control of my child (full name) ____ during this time, I approve and consent to the following safety procedures to ensure the well-being of all participants: ... Trails staff have my permission to review, return, and/or restrict all incoming/outgoing mail to and from my child ..."

Review on 2/22/24 of the facility's "Family Services Handbook" revealed:
- " ... 'FAQ' Frequently Asked Questions ...2. How do I communicate with my child?
Traditional mail and e-mail are the primary ways that you communicate with your child. Most parents type their weekly letter and email them to your TRAILS Primary Therapist. You can send an email letter to your son or daughter by sending it to your child's Primary Therapist's email address with the following as the subject line: Letter for <Child's Name> .
The Primary Therapists will deliver mail during

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their weekly sessions. Therefore, to ensure that they receive a letter for the week, it must be in the Primary Therapist's inbox or mailbox no later than Sunday evening. Staff and therapists collect the students' letters on Wednesday evening and post them on the [electronic system for parents] site by 5:00 pm on Friday of that week. In order to encourage accountability, minimize disruptions, and model limits and boundaries for students, letters are distributed and collected only once a week ...
Students may only receive mail from family members or an adult approved by you and the Primary Therapist. Letters sent from anyone else will be either held by the Primary Therapist until graduation or forwarded to you so that you can deliver this mail to your child when they return home ...
All incoming mail will be screened prior to delivery to your child. Emails and hand-written letters will be screened to ensure that appropriate information gets passed on to your child. Envelopes will be checked for personal belongings and contraband. Letters that your child writes to you will also be read, but will never be altered in any way ..."

Review on 2/12/24 of the facility's "TRAILS Carolina Student Grievance Policy" revealed:
- " ... TRAILS Carolina Student Rights ...
4. Incoming and outgoing mail will not be censored or restricted. This includes mail to and from parents, attorneys and guardians. Incoming mail will be reviewed by staff and sent to the recipient without alteration. All other mail may be restricted by parental request.
5. I will have contact with my parents during the graduation family program, through letters, and an occasional telephone call if deemed therapeutically appropriate and if requested by

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my parents or therapist. I have the right to request phone calls to my parents or guardians, and that my parents or therapist must approve this request ..."

Attempted interview on 2/20/24 with DC #1's parents was unsuccessful due to no response to request for a return call.

Interview on 2/7/24 with Client #2 (with guardian present via speakerphone) revealed:
- He was only able to talk to his parents when he was with his therapist, the Clinical Director.
- He met with the Clinical Director every Tuesday and Thursday.

Interview on 2/9/24 with Client #2's guardians/parents revealed:
- The facility's program was to "give some separation and space for therapeutic reason ..."
- They talked to Client #2's Therapist weekly for the past 6 weeks.

Interview on 2/20/24 with Client #5's Parent revealed:
- Communication with Client #5 was through letters and "a couple" of video calls.
- Conversations with Client #5 were not private as his therapist was present with him at the time of the video calls.

Interview on 2/13/24 with Client #7 revealed:
- She met with her therapist once weekly.
- Could send letters to her parents.
- Thought she could call her parents if she requested it.

Interview on 2/20/24 with Client #7's Parent revealed:
- She was able to have phone calls with Client #7.

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- The phone calls were not private as "someone was with her" at the time of the calls.

Interview on 2/20/24 with FC #22's Parents revealed:
- " ... There is no correspondence. In means of talking to him. It was like 2 weeks. The only time I could talk to him was with [the Clinical Director] on the phone ... We didn't have access to communicate with him while he was there."

Interview on 2/15/24 with the Logistics Coordinator revealed:
- On 2/2/24, DC #1 had "demanded to call his mom ...in our program, they (clients) are not to contact their family at that time ... I don't have authority to say yes or no ....I wanted to say 'yeah, here's my phone' ..."

Interview on 2/13/24 with the Primary Therapist revealed:
- Communication between clients and their parents occurred twice weekly.

Interview on 2/13/24 with the Clinical Director revealed:
- She met with clients for weekly therapy sessions.
- Parents received weekly updates about clients via telephone.

Interview on 2/21/24 with the Executive Director (ED) revealed:
- The communication between parents and clients "typical way is letters back and forth each week ..."
- Letters were never edited by facility staff.
- On the first day of admission, calls were not allowed: "Not typically. We will have that conversation and half the time parents bring them

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V 364	Continued From page 37 and it is 'you saw them five minutes ago, so no' ..." - Clients were allowed to call their parents "Unless there are clinical reasons as to why not and the parent will say they don't want to talk. Sometimes it is clinically useful to wait ..." - Video calls were also allowed between clients and their parents. Interview on 2/21/24 with the Founder/ED revealed: - Communication with parents was "Primarily letter writing ... could be [video calls] or phone calls ..." - If clients wanted to call their parents, "They have to go through grievance process. It is in policy and procedures. The parents have to agree. We are not going to surprise a parent with a call. If it is antsy, we will have the student write that request and then it will work from there ..."	V 364	(V366) 0A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers Background A client death occurred on 2.3.2024, and the incident was relayed verbally to DHHS on the same day followed by the incident report submitted into the IRIS system on 2.4.2024. The DHHS auditors were on site on 2.6.2024. DHHS asked for an Internal investigation report and the Operations Director gave them the information that Counsel would have that documentation. The Incident Report and all known client information was uploaded into IRIS, the Internal Investigation was not uploaded into the database.	
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 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;	V 366	In the future an internal investigation report beyond an Incident report will be submitted. The Internal investigation review will occur within 24 hours of the incident and will consist of review of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; gather other information needed; issue written preliminary findings of fact within five working days of the incident,	

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V 366	Continued From page 38 (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 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	V 366	and will be uploaded into the system. An incident followup timeline will be created and put in place to correct the deficient area of practice. This followup will include timelines indicated in a reporting plan to ensure all necessary reports and timelines are met in the state IRIS reporting system. A timeline and overview of the incident response and reporting manual measures will be put in place to prevent the problem from occurring again. These items will prompt administrative staff to follow the reporting and uploading procedures for incidents. The Operations Director will monitor relevant situations to ensure uploading all relevant reports in a timely manner. They will stay up to date with the IRIS response reporting system to ensure familiarity with reporting procedures. The monitoring will take place quarterly, or as incidents occur.	

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V 366	Continued From page 39 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; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366	*Please note that our creation of a POC for this citation does not indicate full agreement with findings of the state report and discrepancies will be addressed at the scheduled informal conference on April 23 at 1pm. Pg 43 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) Groups with students placed on Assigned Proximity (AP), heightened level of supervision, will have an overnight awake staff present in the group, while the student is on AP. As such, bivy's and (burritos) will no longer be used, even though these have been state approved interventions for safety for the past 15 years. Frequency and insurance that overnight awake staff (OAS) was staffed whenever needed will be reviewed at weekly operations meetings and overseen by the Executive Director.	

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V 366	Continued From page 40 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to issue written preliminary findings of fact within five working days of a level III incident. The findings are: Review on 2/7/24 of Deceased Client #1's (DC #1) record revealed: Review on 2/6/24, 2/8/24, and 2/20/2024 of the North Carolina Incident Response Improvement System (IRIS) revealed:	V 366	*Please note that our creation of a POC for this citation does not indicate full agreement with conclusions of the state report and discrepancies will be addressed at the scheduled informal conference on April 23 at 1pm.	

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-Internal investigation had not been uploaded.

Requests made for review of the facility's internal investigation on 2/7/24, 2/9/24, and 2/20/24, revealed:
- Not provided during the survey.

Interviews on 2/9/24 and 2/21/24 with the Director of Operations revealed:
- She was unsure if an internal investigation had been completed following DC #1's death.
- Had not been present at the facility on 2/3/24.
- Found out about DC #1's death at approximately 3:00 PM on 2/3/24.
- Entered the incident report into IRIS.
- Would have to check with the Executive Director about an internal investigation.
- Spoke with one of the facility's attorneys and was told that the internal investigation was "privileged" and was to be conducted by "outside counsel ..."
- Had not seen any reports other than the one that she entered into IRIS.
- Was aware that the facility staff that had been working in DC #1's cabin at the time of his death (Lead Staff #1, Staff #3, Staff #4, and the Field Shift Coordinator (FSC)) had been "debriefed" by a therapist.

Interviews on 2/9/24 and 2/21/24 with the Executive Director (ED) revealed:
- He was informed of DC #1's death on the morning of Saturday, 2/3/24.

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V 366	Continued From page 42 - On 2/3/24, local law enforcement began an investigation, including interviews with staff and clients. - That night (2/3/24) , Lead Staff #1, Staff #3, Staff #4, and the FSC spent the night at a bunkhouse on the facility's grounds and an "outside therapist check(ed) in on" them. - He and the facility's attorney had a virtual meeting with Lead Staff #1, Staff #3, Staff #4, and FSC on Sunday, 2/4/24. - The virtual meeting included questions about the staffs' involvement with the incident and timeline. - The results of the investigation were "privileged at the moment ..." and could not be released. - As of 2/9/24, the " ... root cause analysis (of the incident investigation); that part is still in process." Interview on 2/21/24 with the Founder/ED revealed: - An internal investigation into DC #1's death began on Sunday, 2/4/24. - An attorney from a nearby city conducted the internal investigation for the facility. - She was not sure if the internal investigation was still going on: " ... No recommendations I can think of. I don't know the answer if it is still going on. Depends on what new comes up ..." No other information was received from the facility by the date of exit.	V 366		
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.	V 512		

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(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.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, 4 of 11 audited staff (Lead Staff #1, Staff #3, Staff #4, and the Field Shift Coordinator (FSC)) failed to protect from harm and neglected 1 of 1 deceased client (DC#1). The findings are:

Observation and interview on 2/6/24 at 12:50PM of Cabin 6 on facility grounds with the Executive Director (ED) and the Founder/ED revealed:
-a wooden cabin that had a covered front porch area attached with 3 windows and front door.
-the floor was plywood.
-there were five bunk beds, two on the left that were parallel with a main wall and three that were placed in T-shape from the other wall.
-the bunkbeds had green mattresses.

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-there were six boarded up windows on the left side of the cabin.
-there was a heat source in the back of the cabin, behind the two bunk beds on the left.
-there was a bathroom in the back to the right with two toilets, a stand-up shower, sink, and spigot.
-a chemical closet was across from the bathroom.
-the back wall had a Dutch Door (no glass) with a latch that could be used to exit the back of the cabin in the event of an emergency.
-per the ED and Founder/ED the windows were boarded on one side to provide privacy from another cabin

Observation on 2/14/24 at 11:01AM of DC #1's Bivy at local law enforcement agency revealed:
-a greenish-brown and black bivy (1-person shelter) made of a Nylon-type material.
-overall shape is a long tube with an opening at the front, like a mouth, that allows for a pole to be inserted to create a half-moon shape for head/gear space.
-The bottom part of the bivy is a nylon type material that appears to be covered with a waterproofing substance that comes up to the sides.
-the opening of the bivy reflects two different portions that can be zipped to close it.
-the first zippered part has a fine black mesh net material over the opening that allows for breathability/visibility/protection from bugs and an outer portion which is the rain fly (that is opaque in visibility) to protect from weather.
-The first mesh layer had a hole in it that was bigger than the size of fist, that started from the seam of the zipper.
-The inside layer had zipper tracks/seam that were fluorescent yellow.

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-A metal alarm pin for the bivy was observed to be on the outside zipper (that was black), had a black tape on it, and a black hair tie with it and was attached to the metal zipper pull with a black zip tie.

Review on 3/7/24 of the bivy manufacturer's website revealed:
"-Nylon 30D Ripstop Upper and 100% Nylon 40D with TPU lamination floor...polyester mesh.
Features: Fabric Performance: Waterproof, breathable, fully seam taped, durable, no-see-um mesh...
Design Features: Single-Pole System, High Volume Toe End, Clamshell Opening, Two Internal Fly Fasteners
-"Dimensions 82 in (inches) X 26 in X 19.8 (footbox tapers)."

Review on 2/13/24 of pictures received from local law enforcement agency revealed:
-White plastic with black ties at both ends resembling the shape of a canoe.
-Golf ball sized object identified as an alarm was zip tied to the zipper of the bivy.

Review on 2/7/24 of DC #1's record revealed:

Review on 2/6/24 and 2/8/24 of the North Carolina Incident Response Improvement System

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(IRIS) revealed:

Requests made for review of the facility's internal investigation on 2/7/24, 2/9/24, and 2/20/24, revealed:
-not provided during the survey.

Finding #1: Staff #3 did not complete required night checks on DC #1 which failed to provide the required supervision.

Review on 2/7/24 of Staff #3's record revealed:
Hire Date: 11/15/23.
Position: Wilderness Field Instructor 1 (WFI) (Support)
-Signed Job Description dated 11/14/23 revealed:
"Conditions of duty...Bathroom Duty and Night Checks...one or more WFI will be assigned each night to bathroom duty and night checks to maintain supervision..."

Review on 2/14/24 and 2/15/24 of the WFI Manual revealed:

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-"Section 2-Supervision and Safety: Supervision Expectations...
-Night Checks: Night Checks are done 3 times per night at 12AM, 3AM, and 6AM (Staff wake up time)...when doing night checks: count all students...you are looking for hair on the head and breathing (to make sure it's not a stuffed sleeping bag). If you are not sure, check (lightly lift up a piece of the sleeping bag and feel for significant weight)."

Review on 2/22/24 of facility Call-In Sheet for Q1(Quarter) 2024 revealed:
-DC #1 was in Echo Group.
-2/3/24, "Echo: [DC #1] [redacted] Rest of Echo has high potential to be grouchy through day."

Interview on 2/6/24 with Lead Staff #2 revealed:
-was a lead wilderness field instructor.
-had been "called in early" to work on 2/3/24 because two staff couldn't work (Staff #3 and Staff #4). He was not told that a client was deceased.
-Staff wake up at 12:00AM, 3:00AM, and 6:00AM for night checks.
-when asked how to perform night checks, "Staff check to see breathing, if (they) are ok in tent, check under the rain fly if they are in a tent...and do a head count."

Interview on 2/12/24 with Staff #3 revealed:
-was a support level wilderness field instructor.
-Lead Staff #1, Staff #3, Staff #4, and FSC were working in cabin 6 on 2/2/24.
-responsible for night checks on 2/2/24 and was on "loo duty" (bathroom duty).
-DC #1 was on "Safety" (Assigned Proximity Supervision (AP)) and slept in a bivy next to Staff #4.

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V 512	Continued From page 48 -"AP, we call that safety...sleep in bivy...(its) small one person tent with alarm and staff member (is) right beside them...Staff (are) within arms-reach at all times." -"He (DC #1) was on 'safety' being his first day." -a solid plastic sheet (called a canoe) was placed around the outside of the bivy, and the rest of the sleeping gear went inside of it (sleeping pad and sleeping bag). -DC #1 was set up to sleep in the corner of the cabin with his head towards the bunk(s), feet against the wall, and assigned staff are on the third side (parallel). -"Heads are together (staff and client)." -completed night checks at 12:00AM, 3:00AM, and 6:00AM.	V 512		

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-"At 6:00 AM I thought I heard shallow breathing from the tent or at least that area."
-couldn't determine at 6:00AM whether the breathing was from Staff #4 or DC #1.
-confirmed that DC #1's bivy was fully enclosed (mesh part and outer rain fly zipped up) and could not actually physically see him (DC #1).
-7:45 AM, "staff (Staff #4) started to wake him up...[DC #1] was not getting up."
-"All we (Staff #3 and Staff #4) could see out of the head side of the bivy was a foot...another staff (Staff #4) undid the alarm and unzipped the bivy...no movement..."

-can contact "primary response (PR)" during overnight if needed (for issues with a student) but thought that person was FSC, who was already with the group.

Review on 3/8/24 of local law enforcement's interview with Staff #3 on 2/15/24 revealed:
-confirmed he was on bathroom duty that night (2/2/24) and responsible for night checks.
-"when a kid that is in the bivy...we call it AP supervision or commonly termed...safety."
-originally, the bivy (DC#1) was fully enclosed and couldn't confirm if that changed throughout the night.

-"...there was an issue with the zipper on the (DC#1's) bivy."
-Gave staff (FSC and Staff #4) his tool bag.

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-"Did check at 3:00AM, he was breathing heavily."
-"Did check at 6:00AM...certain I heard breathing from that section...he was in the bivy...He was no longer heavily breathing..."
-Could not confirm during 3:00am and 6:00am checks whether DC #1's bivy was open or closed.
-Staff #3 couldn't verify that DC #1 was present during his night checks.
- "I heard mumbling between hours of 3:00-6:00am..so I went over there...I heard shallower breathing...can't say for certain if the breathing was from him or [Staff #4] because their heads were at same level..."
-"...couldn't physically see the inside of bivy because it wasn't clear...could see it was occupied. heard breathing from that space."
-was trained to do night checks.
-was trained to look physically or audibly for confirmation that a client was alive when doing night checks.
-"I didn't check as thoroughly as I should have."
-"My actions that night was to perform night checks...that was my responsibility, which I failed on."
-" ...I do feel like the bivy had a lot to do with it (DC#1 passing away) ..."
-" ...Suffocation is always possible if equipment is being used wrong ..."

Interview on 2/8/24 with the FSC revealed:
-was the field shift coordinator on 2/2/24.
-Lead Staff #1, Staff #3, Staff #4, and herself were working in Cabin 6 on 2/2/24.
-was the supervisor.
-when asked if Staff #3 did his checks, "I'm not

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V 512	Continued From page 51 entirely sure...we spoke afterwards, and he said that he had...but I'm not sure." Finding #2: Lead Staff #1, Staff #4, and FSC failed to provide the required supervision that protected DC #1 from harm and neglect and failed to follow internal procedure for increased sleeping modification with the bivy. Review on 2/7/24 of Lead Staff #1's record revealed: Hire Date: 9/11/23. Position: Wilderness Field Instructor (effective (eff) 1/1/24.) Review on 2/7/24 of Staff #4's record revealed: Hire Date: 8/7/23. Position: Wilderness Field Instructor (WFI). Review on 2/7/24 of FSC's record revealed: Hire Date: 12/13/22. Position: Field Shift Coordinator (eff 1/16/24). Review on 2/14/24 and 2/15/24 of the facility's internal procedure for "Increased Sleeping Precaution (Bivvy Modification)" revealed: -"When a student is on AP (Assigned Proximity) one of the 3 automatic requirements is an increased sleeping precaution. The Bivvy is the default option... -The bivvy must be placed inside of a canoe with the Walls wrapped around the sides. -The bivvy must have the screen closed at the head in order for staff to be able to see the student when needed. -A zipper alarm system must be used once the student is asleep. Until they fall asleep they can be in the bivvy with out the alarm with staff next to them. -Attaching the alarm:	V 512		

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V 512	Continued From page 52 -The pin of the alarm must be attached to the top zipper of the screen with a small zip tie through the metal on both parts. -The key ring on the alarm then goes around the pole and the pole is secured in place with the velcro tab. -Bells must be attached to the bottom of the bivvy and the velcro tab where the pole is secured. -Attachments between the alarm and the Bivvy or bells must utilize a small zip tie to ensure that the system is secure but can also be removed by the staff if needed. -Sleeping arrangement -A staff member needs to sleep head to head next to the student AND one of the following -with another staff member sideways at the head of the bivvy. -OR the student in a corner of a room with the head and one side against a wall. -Sleeping Tarp-only to be used when specifically approved by either the therapist or the Field Director..." Interview on 2/7/24 with Client #2 with guardian present via speaker phone revealed: -would sleep in the bivy on the floor of the cabin if you were on safety. -"Staff sleep around us...one next to entrance, one in back, and one next to bivy." -"alarm on bivy, if you unclip the alarm, it makes a bird noise." -"must ask staff to get out of the bivy." Interview on 2/7/24 with Client #3 with guardian	V 512		

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present via speaker phone revealed:
-when asked where he slept in the cabin, if on Safety, "on floor in bivy...not on safety, in bunk with sleeping bag and liner."
-if you need help while in the bivy, "you have to tap them (staff) somehow...you roll on top of them...it's really hard to wake staff up."

-he (DC #1) was in the bivy on the floor.
-was not sure about night checks with staff.

Interview on 2/7/24 with Client #4 with guardian present revealed:

- Safety is, "sleeping in a bivy sac with security, basically, an alarm...on the floor..."
-"Staff sleep on floor next to you."
- the alarm is loud.
-"staff set alarm (to bivy) when they think you're asleep..."
-Before they (staff) wake anyone up, they take the alarm off (the bivy).
-staff have head lamps for night checks.
-"did not see any lights that night (2/2/24)."

Interview on 2/8/24 and 2/12/24 with the Lead Staff #1 revealed:
-confirmed he was the lead staff that night, responsible for the group, administered medications (meds).
-gave DC#1 his meds on 2/2/24.
-stationed (to sleep) by the front door of the cabin (Cabin 6).
-Staff #3 was responsible for completing night checks.
-Didn't know if Staff #3 completed those checks,

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"I was asleep."
-"Any student coming in is assigned AP."
- DC #1 was assigned Staff #4 as his AP staff on 2/2/24 and slept in the bivy.
-"It's like a first precautionary that every student goes through..."
-"...(the) hard shell cover that goes around it (outer bivy layer)...most students don't' like that...makes it feel claustrophobic, never had a student ask to close it..."
-when asked if DC #1's bivy was damaged, "To my knowledge no...I think the netting might have had a small tear...I didn't examine it..."

-last interaction with DC#1 was at 12:30AM and he got in his sleeping bag and went to sleep.
-woke up in am at 7am, went for laundry and did "call in."
-returned to the cabin around 7:40AM and turned on the lights.

-sent Staff #4 to call 911 and radioed FSC.

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Interview on 2/13/24 with the Clinical Director revealed:
-clinical director and acting therapist for Echo group.
-was not on campus when DC #1 arrived.

-received a text message from Lead Staff #1 at 7:37AM regarding DC #1.

Observation on 2/13/24 of a text message dated 2/3/24 at 7:37AM on the Clinical Director's (CD) phone from Lead Staff #1 revealed:

Attempted interview on 2/12/24 with Staff #4 revealed:
-two voicemails left on 2/12/24 were unreturned.
-2/14/24, legal counsel for Staff #4 advised the Division of Health Service Regulation there would be "no comment."

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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 56 Review on 2/7/24 of local law enforcement agency's interview dated 2/3/24 with Staff #4 revealed: -went to help with DC #1's intake around 11:30AM on 2/2/24. -DC #1 was later brought to the group and placed on "safety." - assigned staff to DC#1 and had to be "in arms reach." -"[DC#1] was sleeping in the floor and not a bunk...its protocol."	V 512		

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V 512	Continued From page 57 -nodded and answered "yes" to the question, do you think he suffocated? -he and the camp were responsible for DC #1's death. -when asked what he could have done, "I could have opened it up, repositioned him (in the bivy)." Interview on 2/8/24 with the FSC revealed: -was the FSC. -did a cursory check (general scan) of DC#1 during intake and noted -completed pocket checks on DC #1 as well. -took DC #1 to join the other kids around 3:00PM and exchanged DC#1's medications with Lead Staff #1. -advised Staff #4 that DC #1 was on AP (safety). -told DC #1 around 9:00PM, "ok we have to get in the bivy." -slept in the middle of the cabin (between bunks). -DC #1 was in the corner of the cabin with his feet towards the corner of the wall and head towards the bunks. -there was a problem with the zipper part of the	V 512		

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V 512	Continued From page 58 bivy, it came off and she put it in her pocket. -DC#1 was let out of the bivy and he fell asleep on Staff #4's pad. -DC#1 went back into the bivy around 10:00pm. -"We let him out the first time...and second time...he stayed inside the bivy..." -heard DC #1 snoring and went to bed for the night. -woke up around 6:00AM and went out of the cabin. -Lead Staff #1 reported over walkie talkie that a student was unresponsive. -DC#1 was wearing a red hoodie.	V 512		

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V 512	Continued From page 59	V 512		

Review on 3/9/24 of Law Enforcement's interview with the FSC on 2/14/24 revealed:
-was the FSC.

-Staff #4 was also present during DC #1's intake process.
-DC #1 was on AP (Safety).
-Lead Staff #1, Staff #3, Staff #4 and FSC worked in cabin 6 on 2/2/24.
-not present for medication administration at the cabin.
-In regard to DC #1's bivy, two zippers (on inside like the tent), " ...the head of the zipper came off (exterior) and put it in my pocket ..."
-On DC#1's bivy, had to get tool kit as the zipper was attached to mesh and the entire part came off.
-With DC#1's bivy, there were 2 layers. The screen part was where the zipper fell off, so the wind shell part was zipped up.
-The alarm was zip tied one to the tent pole and one to the zipper.
-Alarm was on outside of bivy.

-Staff #4 let him out of the bivy and DC #1 fell asleep on Staff #4's sleeping bag.
-told DC #1 it was time to get back inside the bivy.

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V 512	Continued From page 60 -FSC went to sleep and "heard snoring." -could not corroborate if DC #1 was breathing, talking, or making noise between 3:00AM-6:00AM because she was asleep. -woke up around 5:45AM- 6:00AM and left the cabin for other duties. -around 7:50AM, overheard Lead Staff #1 through the walkie-talkie that a student was unresponsive. -"with behavioral stuff, we active(ly) listen, validate, give options, and if that doesn't work we disengage...and if it continues and its unmanageable, we reach out to a therapist for further instruction." -"A lot of the kids we have come in will thrash and cry their first night." -had not been given instruction before by facility staff to pull a kid out of a bivy and check their vitals if escalated. -confirmed DC #1 was let out of the bivy once that night. -couldn't confirm if Staff #3 did his night checks. -confirmed DC #1's bivy was damaged and explained there were 2 layers.	V 512		

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-"the screen part is where zipper part fell off, so we zipped up the wind shell part (outer layer)."
-"Never seen a kid turn around in the bivy."
-"I think if he did flip around there, there would be a lot of noise."
-her job was to "observe their nighttime routine so I could fill out paperwork...coach them (staff)..."
-advised she wanted to speak to an attorney.

Interview on 2/15/24 with a logistics coordinator revealed:
-did not provide new students with the bivy system.
-there was one Bivy per group (students assigned in groups by age/gender)
-"the bivy is [facility]...solo tent is what they get in backpack."
-"Echo group presumably already had one...I didn't give them one(bivy)."

Interview on 2/21/24 with the Executive Director (ED) revealed:
-oversaw day to day operations.
-was notified by primary response (PR) regarding DC #1 not being responsive on 2/3/24 around 8:00AM.
-did not see DC #1's body on scene in the cabin.
-started using the bivy system with an alarm, middle of last fall and "felt like it gave a better sense of privacy and easier to digest than the 'burrito' for clients."
-never had issues with it before (bivy).
-reported other wilderness programs used a bivy.
-with night checks, staff were supposed to confirm that a client was physically there, "without taking them out of the sleeping bag...supposed to look for movement, breathing, those types of things."

Interview on 2/21/24 with the Founder/ED

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V 512	Continued From page 62 evealed: - oversaw the ED. -"I know what licensing standards are and what's best practice." -"Don't have a lot of first-hand knowledge about bivy system." - night checks are supposed to be "visual." Interview on 2/7/24 with local law enforcement revealed: -first responders were dispatched at 7:45AM on 2/3/24. -staff were supposed to be checking on DC #1 through the night at 3:00AM and 6:00AM. -"[DC #1] slept on the floor of the cabin (cabin 6), on a plastic sheet...inside a sleeping bag and in a Bivy." -law enforcement was dispatched to the scene at 8:28AM Interview on 2/8/24 and 3/6/24 with the local Medical Examiner revealed: -observed DC #1 at the scene. -the body had been taken out of the bivy and it was crumpled (bivy) in the corner of the cabin.	V 512		

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Review on 2/16/24 of the Plan of Protection dated 2/16/24 written by the Operations Director revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
The 4 staff present in cabin 6 on the evening of Feb 2-Feb 3(2024) were put on leave after the incident. All students are discharged on Feb 16 (2024).
Describe your plans to make sure the above happens:
A meeting will discuss and review current supervision for day and night. An alternative policy and procedure will be proposed by March 4 (2024) for review."

This facility is licensed to provide residential therapeutic camp services to children and adolescents with diagnoses such as Attention Deficit Hyperactivity Disorder, Autism, Depression, Disruptive Mood Dysregulation Disorder, eating disorders, and substance use disorders. DC #1 was a physically healthy child that was admitted to Trails Carolina on 2/2/24 in the afternoon and was pronounced deceased the morning of 2/3/24 by authorities. DC #1 was assigned to the ECHO group in cabin 6 with four other clients on 2/2/24. There were four staff present in cabin 6 on 2/2/24; all of whom were responsible for the safety and wellbeing of the clients. DC #1 was placed in a bivy with an alarm to sleep in on his first night, encased in plastic canoe due to AP supervision (safety/heightened supervision) with an assigned staff (Staff #4) next to him (within

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V 512	Continued From page 64 arm's reach) for safety and supervision. DC #1 was let out of the bivy one time by FSC and Staff #4 in the overnight hours of 2/2/24. He fell asleep on Staff #4's mattress and was then woken up and instructed to go back in the bivy after a few minutes. no one checked on him inside the bivy for his wellbeing despite being non-responsive to staff prompts. Staff #3 was assigned to complete night checks on 2/2/24. He confirmed that he did not physically see DC #1 during his checks at 3:00 AM and 6:00AM as the outside of the bivy was zipped closed. He admitted that he could not tell if the breathing was from DC #1 or from Staff #4 during those times. Therefore, Staff #3 couldn't determine whether DC#1 was alive. Lead Staff #1, FSC, and Staff #4, failed to provide supervision or consult with another supervisor during the night when DC #1 was escalated. They failed to follow internal procedure for sleeping modification for students. They could not visually assess DC#1 because the outside of the bivy was closed. The bivy was alsodamaged and the zipper was broken. FSC told Staff #4 to stand against a wall and to disengage when DC #1 Staff #4, the assigned AP "arms-length staff," did not engage and went to bed. Based on discrepancies in interviews, it could not be determined what interventions took place to assist DC #1	V 512		

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V 512	Continued From page 65 after 12:00AM. [redacted] DC #1's body was found turned around in the bivy the next morning at 7:45AM and pronounced deceased. The medical examiner's report and toxicology are pending, however preliminary results reported the death as unnatural. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days.	V 512	(V513) 10A NCAC 27E .0101 Least Restrictive Alternative Groups with students placed on Assigned Proximity (AP), heightened level of supervision, will have an overnight awake staff present in the group, while the student is on AP. As such, bivy's and tarping (burritos) will not be used. Frequency and insurance that overnight awake staff (OAS) will be staffed whenever needed will be reviewed at weekly operations meetings and overseen by the Executive Director. *Please note that our creation of a POC for this citation does not indicate full agreement with conclusions of the state report and discrepancies will be addressed at the scheduled informal conference on April 23 at 1pm. For Example: a) The report states there were 23 counts of staff on AP with students of the opposite sex. The bivvy policy does NOT require staff to be same sex. b) The report implies that students	
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff.	V 513		

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V 513	Continued From page 66	V 513	sleeping on a sleeping pad on the floor in a cabin jeopardizes their dignity. The state has signed off on this safety precaution for the past 15 years, until now.	

(b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:
(1) using the intervention as a last resort; and
(2) employing the intervention by people trained in its use.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to provide services using the least restrictive and most appropriate methods that promoted a safe environment and was designed to ensure dignity and respect. The findings are:

Observation and interview on 2/6/24 at 12:50 pm of Cabin 6 on facility grounds with Executive Director (ED) and Founder/ED revealed:
-A wooden cabin that had a covered front porch area attached with windows and front door.
-The floor was plywood.
-There were five bunk beds, two on the left that were parallel with a main wall and three that were placed in T-shape from the other wall.
-The bunkbeds had green mattresses.
-There were six boarded up windows on the left side of the cabin.
-There was a heat source in the back of the cabin, behind the 2 bunk beds on the left.
-There was a bathroom in the back to the right with two toilets, a stand up shower, sink, and spigot.
-A chemical closet was across from the

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bathroom.
-The back wall had a Dutch Door (no glass) with a latch that could be used to exit the back of the cabin in the event of an emergency.
-Per the ED and Founder/ED, The windows were boarded up on one side to provide privacy from another cabin further up the hill and DC #1 slept in the corner to the far left side.

Observation on 2/14/24 at 11:01AM of DC #1's Bivy at local law enforcement agency revealed:
-A greenish-brown and black bivy (1-person shelter) made of a Nylon-type material.
-Overall shape is a long tube with an opening at the front, like a mouth, that allows for a pole to be inserted to create a half-moon shape for head/gear space.
-The bottom part of the bivy is a nylon type material that appears to be covered with a waterproofing substance that comes up to the sides.
-The opening of the bivy reflects two different portions that can be zipped to close it; the first, a fine black mesh net material over the opening that has a zipper that allows for breathability/visibility/protection from bugs and an outer portion which is the rain fly (that is opaque in visibility) to protect from weather.
-The first mesh layer had a hole in it that was bigger than the size of fist, that started from the seam of the zipper.
-This inside layer had zipper tracks/seam that were fluorescent yellow.
-A metal alarm pin for the bivy was observed to be on the outside zipper (that was black), had a black tape on it, and a black hair tie with it and was attached to the metal zipper pull with a black zip tie.

Review on 3/7/24 of the bivy manufacturer's

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website revealed:
"-Nylon 30D Ripstop Upper and 100% Nylon 40D with TPU lamination floor ...polyester mesh.
Features: Fabric Performance: Waterproof, breathable, fully seam taped, durable, no-see-um mesh ...
Design Features: Single-Pole System, High Volume Toe End, Clamshell Opening, Two Internal Fly Fasteners
"-Dimensions 82 in (inches) X 26 in X 19.8 (footbox tapers)."

Review on 2/13/24 of pictures received from local law enforcement agency revealed:
-White plastic with black ties at both ends resembling the shape of a canoe.
-Golf ball sized object identified as an alarm was zip tied to the zipper of the bivy.

Review on 2/14/24 and 2/15/24 of the Trails Carolina Policy "4.03. Safety Levels" revised on 1/23/23 revealed:
-"Procedure:
1. The student is placed on Assigned Proximity when they violate safety code ...
3. ...A plan will be made with the primary therapist on how a student can exhibit safety behaviors and move off of Assigned Proximity.
4. The staff will inform the student of the decision, educate the student about the consequences, limitations, and expectations of Assigned Proximity, and immediately implement safety phase requirements (see expectations of safety phase).
5. Assigned Proximity restrictions can range from 18 - 72 hours. Restrictions can last longer than this only if clinically indicated by the need to keep students and others safe. If extension of safety phase longer than 72 hours is indicated, the student's primary therapist will document clinical

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justification for this extension in the student case notes.
6. If the student reaches the 72 hour limit on Assigned Proxmity prior to completing all the requirements of this phase, and is determined by the student's therapist that they are no longer a safety risk, they will return to Assigned Relational Supervision or Relational Supervision privileges until they complete all the safety phase requirements, and the treatment team grants a higher phase.
7. The student must complete all safety requirements to enable them to return to Assigned Relational Supervision or Relational Supervision .
8. When the student has completed the requirements of Assigned Proximity they must get approval from the Primary Therapist or Clinical Director to return to a lower level of supervision .
9. A student may return to Assigned Relational Supervision or Relational Supervision as determined by the Primary therapist or Clinical Director.
10. Expectations of Assigned Proximity : ...
e. A student will be placed on arm's length with staff for the duration of safety phase.
f. At night, the student will be required sleep in a burrito unless an exception is approved by the Clinical or Executive Director ..."

Review on 2/14/24 and 2/15/24 of the facility's undated internal procedure for "Increased Sleeping Precaution (Bivvy Modication)" revealed:
"When a student is on AP (Assigned Proximity) one of the 3 automatic requirements is an increased sleeping precaution. The Bivvy is the default option, a sleeping tarp is only to be used in specific instances and approved by the primary therapist or a Director.
Bivvy Sack:

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Student Prep:
-Approach the bivvy in a gentle way. Make it clear that this is to ensure their safety and they can get out whenever they feel the need, they just have to tell staff. Hear their concerns and validate any fears, frustrations, or emotions coming up.

-Before the Student enters the Bivvy a pocket check must be conducted. Only things necessary for sleeping are permitted. These restricted to:
-Sleeping pad.
-Sleeping bag
-No more than 2 layers of clothing
-1 clothing item for a "Pillow"
-Stuffy (if approved by therapist)
-All other Items must be left with staff or outside with the rest of their belongings.

-Alarm and bivvy set up
-A sleeping pad must be inside of the bivvy itself.
-The bivvy must be placed inside of a canoe with the Walls wrapped around the sides.
-The bivvy must have the screen closed at the head in order for staff to be able to see the student when needed.
-A zipper alarm system must be used once the student is asleep. Until they fall asleep they can be in the bivvy with out the alarm with staff next to them.
-Attaching the alarm:
-The pin of the alarm must be attached to the top zipper of the screen with a small zip tie through the metal on both parts.
-The Key ring on the alarm then goes around the pole and the pole is secured in place with the velcro tab.
-Bells must be attached to the bottom of the bivvy and the velcro tab where the pole is secured.
-Attachments between the alarm and the Bivvy or

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bells must utilize a small zip tie to ensure that the system is secure but can also be removed by the staff if needed.

-Sleeping arrangement
-A staff member needs to sleep head to head next to the student AND one of the following:
-with another staff member sideways at the head of the bivvy.
-OR the student in a corner of a room with the head and one side against a wall.
-Sleeping Tarp-only to be used when specifically approved by either the therapist or the Field Director.
-Sleeping Tarp There are two configurations:
-2 staff option: End of tarp is under Staff A, over student, and Under Staff B-1 staff option: Tarp wraps around student and sleeping bag like a "taco" and staff sleep on top of two open ends
-When doing a sleeping tarp in a cabin be sure to NOT use mattress in configuration and have student on cabin floor. Student should be sleeping in a canoe under the tarp.
-Note, the exit point of a sleeping tarp is out the top. Obstructing this area (eg. wall, staff, tent wall) helps increase the effectiveness of the sleeping tarp.
-Do not have the tarp too tight around the student.
-This also allows staff to monitor the student closer throughout the night.
-Acknowledge that this can be even more stressful for students who are already at high risk. Ensure that you present it as a tool for ensuring safety and wellbeing."

Review on 2/14/24 and 2/15/24 of the facility Wilderness Field Instructor Manual revealed:
-"Section 2 - Supervision and Safety ...
Sleeping Tarp (aka "Burrito")

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When students are on AP (and sometimes for other reasons given by a therapist), they are to be tarped at night. This entails placing a tarp over the student's body (but not head) with the ends placed under adjacent staff. When done correctly, if the student attempts to move more than a normal sleeper would, it creates enough noise to alert staff. This can help prevent self-harm and run attempts. Staff that are tarping need to be of the same sex as the student being tarped.
There are two techniques for tarping:
"Taco": A staff of the same sex is positioned on each side of the student. Each staff sleeps on top of one side of the tarp, and the middle portion goes over the student. This is the setup pictured above, and is preferred when your team has the staff needed to match genders appropriately.
"Burrito": The student sleeps on top of one end of the tarp, and the rest of the tarp is wrapped over the student and then placed under an adjacent staffs sleeping setup.
Before putting the student into their tarp setup, take the opportunity to perform a thorough pocket check.
When sleeping in a cabin, the student is to be tarped on the floor, sleeping on a pad. Do not use a mattress ...
Assigned Proximity students will ALWAYS sleep in a 'burrito' unless IPM (Individual Precautionary Measures) dictates otherwise ..."

Review on 2/7/24 of Deceased Client #1's (DC #1) record revealed:

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V 513	Continued From page 73 Review on 2/22/24 of Client #2's record revealed: Review on 2/22/24 of Client #3's record revealed: Review on 2/22/24 of Client #4's record revealed: Review on 2/22/24 of Client #5's record revealed: Review on 2/22/24 of Client #6's record revealed: Review on 2/22/24 of Client #7's record revealed:	V 513		

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V 513	Continued From page 74 Review on 2/29/24 of Client #11's record revealed: Review on 3/15/24 of facility face sheets for Unaudited Clients revealed: -Client #12: -Client #13: Review on 2/29/24 of Former Client (FC) #18's record revealed: Age: not provided. Diagnoses: requested but not provided. Review on 2/29/24 of FC #19's record revealed: Age: not provided.	V 513		

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Review on 3/15/24 of facility client discharge list revealed:
-FC #23's Discharge Date:
-FC #24's Discharge Date:
-FC #25's Discharge Date:
-FC #26's Discharge Date:

Review on 2/22/24 of the Facility Call In Sheet for 2023 Quarter 4 and 2024 revealed:
-Clients that were on AP for 72 hours or longer:
-Client #2:
-Client #4:
-Client #6:
-Client #7:
-Client #11:
-Client #12:
-Client #13:
-FC #18:
-FC #19:
-FC #19:
-FC #23:
-FC #24:
-FC #25:
-Clients that were on AP with staff assigned of opposite sex:
-Client #6
-Client #7
-FC #19
-FC #24
-FC #26

Interview on 2/7/24 with Client #2 (with guardian present via speakerphone) revealed:
-Staff sleep around us in cabin. One next to entrance, one in back (Loo), and one next to you

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in the bivy.
-If you are on safety, you sleep in a bivy on the floor.
-"Alarm on bivy, if you unclip the alarm, it makes a bird noise."
-"Must ask staff to get out of the bivy." Staff were in arms length.

Interview on 2/7/24 with Client #3 (with guardian present via speakerphone) revealed:
-when asked where he slept in the cabin, if on safey, "on floor, in bivy...not on safety, in bunk with sleeping bag and liner."
-On safety when you first arrive.
-You are on the floor and staff are parallel to you.
-To get out of the bivy, "have to tap them (staff) somehow ...you roll on top of them ..."
-It is hard to wake staff up.
-DC #1 was in a bivy on the floor.
-The mother was not aware that Client #3 slept in a bivy the first night.

Interview on 2/7/24 with Client #4 (with guardian present) revealed:
-Safety is, "sleeping in a bivy sac with security, basically, an alarm...on the floor..."
-Have to ask to go to the bathroom. Hard to do without waking everyone up.
-"Staff sleep on the floor next to you."
-"Staff set alarm (to bivy) when they think you're asleep..."

Interview on 2/20/24 with parent of Client #5 revealed:
-Was not aware of the bivy protocol. "I had to google what a bivy was."
-"He (Client #5) later told me ..."

Interview on 2/13/24 with Client #6 revealed:
-"As soon as you get on it (safety/AP), they make

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a plan (to get off)...a day, a few days, a week."
-First night, "I rolled on the alarm and it went off."

Interview on 2/13/24 with Client #7 revealed:
-Night one you sleep in the bivy "...until you speak to the therapist."
-Didn't try to get out of the bivy because "...try to open and the alarm goes off."

Interview on 2/20/24 with parent of Client #7 revealed:
-Was aware of alarm system but was unsure of how it worked. Hadn't seen the system on a bivy sack.

Review on 3/8/24 and 3/11/24 of local law enforcement agency interview with the Field Shift Coordinator dated 2/14/24 revealed:
-When clients first come in or show signs of hurting themselves or others, damage to property, or running away, they are put on AP.
-A bivy is a very small tent. "We have an alarm on it."
-"Ground plastic thing underneath it and then the bivy and then the sleeping bag and then the kid"
-The plastic is on the floor.
-A sleeping pad goes inside the bivy. The mattresses are for the bunks.
-" ...the screen part was but the zipper part fell off so we zipped up the wind shell part ..."
-" ...a lot of the kids that we have come in will thrash and cry on their first night."
-If client unzips the bivy, it sets off an alarm. The alarm is padded and the size of a golf ball.
-There was an alarm if they try to get out, staff would be alerted by the alarm.
-Prior process was the burrito. A tarp folded over with staff on either side. If the client moved, staff would feel the tarp move.
-The facility was workshopping a new idea for AP

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and landed on the bivy system.
-The alarm has always been used on the bivy at this facility.

Review on 3/11/24 of local law enforcement agency interview with Staff #4 dated 2/3/24 revealed:
-Description of bivy, " ...not trying to keep you confined or locked in it's just for your safety. And if you ever need to get out, you can just yell out for us and we can let you out and unzip you ..."
-Did not know why the bivy was on the floor and not the bed. "Protocol it (bivy) goes on the floor."

Review on 3/8/24, 3/12/24 and 3/14/24 of local law enforcement agency interview with Staff #3 dated 2/15/24 revealed:
-Use the bivy for supervision purposes.

-"He (DC #1) was in the corner with him right up against two of the walls. His feet at one wall and him parallel with another wall. A bunk by his head and then the staff member on the other side of him blocking him off entirely from that way. So he was boxed in 4 directions. He was right up against that side wall ..."
-"It (bivy) is intended to where they cannot get out of it without us knowing."
-"They wake up this person right here (points to where staff member would be sleeping) ...and that person opens bivy."
-"None that I have been trained on." (protocol for claustrophobia). "There is an alternative to bivy. It wouldn't be night of that we would make that decision. Burrito. It is more claustrophobic."
-Had been trained that the bivy was a better alternative to the burrito.

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-Supervision of the bivy was to make sure they (clients) could not get away or get out of the bivy without someone knowing.
-"The layout of when they are on safety is designed to where they should not be able to move around without somebody knowing ..."
-"If they (clients) want to get up and use the restroom all they have to do is ask. If they want to get up and walk around ...all they have to do is ask ...we let them out ..."
-"The application of it (the bivy) I had issues with beforehand. It's not clear. We can't see them."
-" ...how are we supposed to keep kids safe with no better alternative immediately ..."
-"The burrito seemed even more constrictive ...sounds more inhumane ..."
-" ...The bivy is supposed to be more comfortable ...than wrapping someone in a tarp (burrito)."
-"I absolutely agree with that (with the bivy being traumatic)."
-"That precaution (safety-bivy) is more to prevent harm than it is to encourage therapy...That is why we have to go to therapists if we are going to take them off ..."
-All new students were automatically put on advanced supervision until therapists say otherwise.
-There was an issue with the zipper on DC #1's bivy and staff needed a zip tie out of the tool bag.
-Don't use the tarps anymore because bivies were safer and more comfortable than the burrito.
-During orientation was told the bivy was safer and more comfortable.

Interview on 2/12/24 with Staff #3 revealed:
-AP is "...mostly commonly called safety..."They have to sleep in the bivy...easier to keep track of them..."
-A bivy is a small one-person tent with an alarm and staff member right beside them. Staff was

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V 513	Continued From page 80 within arms reach at all times. -"You should be able to reach out of the sleeping bag and touch them." -"The goal was to sandwich the clients in and be as close as possible to where they cannot even roll over without you knowing. If they roll over they would roll over onto you and you would know it." -Staff should be able to reach out of sleeping bag and touch them. -Plastic is under the burrito and bivy. " ...Solid plastic sheet underneath ...It was loud. Stick it under the bivy and the rest of the sleeping gear goes in the bivy." -Staff in the field can put a client on safety if they have dangerous behaviors but only therapist can take off. "Typically they are on multiple days (AP) . It can last fewer...They (therapists) don't have speak to them. But the therapist will tell us. The mood that caused the behaviors takes a while to dissipate. But the therapist will decide." -"...and all new students start on safety." -The bivy was set up so that 3 sides are covered and the staff are one of those side. They sleep head to head. The clients head toward other bunk, against the wall, in toward the cabin. -"We do our best to make sure they don't see us set up alarm ..." -There were issues with zipper of the bivy. The staff were trying to get the alarm set up because of issue with the zipper. -Not sure how long new students stay in the bivy. They were switching from burrito to bivy when I first started. -Clients sleep in the bivy with the alarm on it if they are on AP. -Staff sleeps on tarp next to student in the burrito. -Changed within the last 6 months from burrito to the bivy. -Shift training on the bivy was led by field	V 513		

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management on how to set it up.
-There was a training on the bivy the Wednesday before DC #1 passed away.

Interview on 2/6/24 with the Lead Staff #2 revealed:
-New clients stay in the bivy until after first therapy session to figure where they are and determine protocol.
-They sleep in backpacking bivy and keep fly open until they go to bed. An alarm system that goes off, goes on zipper. IT would make a loud noise, sounds like a siren.
-The therapist makes that decision of when they come off protocol. New clients typically one night.
-They see the therapist right away and assign precautions.
Gives a good sense of where you are at.
-Field staff were allowed to place kids on AP but not take them off. Have to go through a therapist to remove that precaution.
-The facility started using the bivy system a couple of months ago.
-Types of clients varies a lot. Their behaviors don't transfer well in school setting. Some have trouble regulating emotions, a few are on the spectrum, history of self harm, and some attempted suicide.

Interview on 2/7/24 and 2/12/24 with the Lead Staff #1 revealed:
-The bivy was used the first night in order to make enough noise to alert staff around them. It's a first precautionary that every student goes through.
-A plastic sheet goes on the ground and the client gets in sleeping bag and then inside the bivy.
-The bivy has an alarm.
-A pull pin is attached to the zipper, and then the pull pin is attached to the bivy

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-"If zipper unzips the alarm pops open."
-Staff was assigned to sleep next to them and slept head to head. They can alert staff at any time.
-Close at least the mesh netting on the bivy. We can close the top if they want to make it darker.
-" ...There is a mesh zipper and then one that is alarmed. Hard shell cover. Most students don't like that. It makes you feel claustrophobic. I have never had a student want that. I have never had to open it. If I did, I would crack it just to point my light in there."
-" ...I think the netting may have had a small tear in it. It was handed down from staff and wasn't told anything and I didn't check."
-If clients are on safety they have to stay in the bivy.
-Therapist gives a set of outcomes to be taken off safety, as long as it takes them to complete.

Interview on 2/7/24 with the Field Shift Coordinator revealed:
-On AP, staff are in arms length of the clients and the clients also have to sleep in the bivy.

Interview on 2/13/24 with Anonymous Staff #6 revealed:
-AP also called safety. One staff within arms reach of student. Would have to sleep in burrito or bivy.
-The alarm goes on the zipper of the bivy.
-Trained staff on burrito but denied personally having trained staff on bivy.
-Former Field Director #13 was previous trainer.
-Burrito was the tarp placed under student, then over them and staff will sleep next to them on other side of tarp.
-Started using the bivy system last year.

Interview on 2/20/24 with the Former Staff Field

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Director #13 revealed:
-If the bivy was broken, notify Primary Response (PR) and let them know.
-Training on bivy was completed by the facility.
-If protocol is broken, contact PR.

Interview on 2/15/24 with the Logistics Coordinator revealed:
-Training for the bivy included: how to set it up, alarm, system, functions, the intentions, intended use, ring is through pull, setting it up so couldn't be diffused inside the bivy.
-Felt that the alarm was easy to get off.
-"Last I heard we moved back to the old system with a tarp."

Interview on 2/13/24 with the Primary Therapist revealed:
-Role was Primary Therapist.
-Had been in this role for 3 years and 11 months.
-AP level of care is always in arm reach of staff.
-AP would have assigned staff and use the bivy system around supervision.
-Generally AP will max out at 72 hours.
-Staff can move a client up a level but needs direct feedback from therapist to move them down.
-Didn't have enough info to speak on bivy system. " ...Can't speak accurately."
-Hadn't been trained on the bivy system.
-The bivy system had been used for several months.
-"It is less restrictive than alternatives ..." even with an alarm.
-It was automatic if assigned on AP they are put in bivy.
-They can unzip the bivy and it will set off alarm. They have to notify staff that they need to get out.
-When alarm is placed on zipper, there is an intention to get out ...

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	MHL088-020	A. BUILDING: ______ B. WING ______	R 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAILS CAROLINA	500 WINDING GAP ROAD LAKE TOXAWAY, NC 28747

(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
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-" ...enclosed in the bivy and that keeps them (clients) there."
-The facility has done awake staff but only when significant risk of elopement.
-"If they require awake staff at night, they are not a fit for our program."

Interview on 2/13/24 with the Clinical Director revealed:
-Had been the Clinical Director since July of 2015.
-AP is assigned proximity and staff are to be in arms length of that person.
-Staff can bump clients up levels of safety but not down.
-Clients have to complete safety plan and therapists will remove from AP.
-Clients would sleep in bivy with alarm attached to it when on AP.
-At intake, assigned on AP until a therapist comes out.
-How the bivy works ..."Haven't seen one in action. I have seen one at [local outdoor store] ..."
-Clients can be on AP " ...as long as needed. I don't know that there is a minimum ..."
-Seems better approach than tarp system for proximity.
-"Just zip it up and put on the alarm ...I haven't seen it in place."
-Alarm is attached to the zipper.
-Field Director #6 did the training on the bivy for staff.

Interview on 2/21/24 with the Operations Director revealed:
-Started using the bivy system " ...pretty recent. It is considered a more comfortable scenario ..."
-"Considered least restrictive. It is a less restrictive way to ensure that a student doesn't wake up and run away."

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Interview on 2/21/24 with the ED revealed:
-With assigned proximity, a specific staff is within an arms length of that student. The staff can bump up a level but only therapist can reduce level.
-Part of that assigned proximity was sleeping in a bivy.
-Implemented in the middle of last fall.
-"Other programs began using that (bivy) instead of tarping system. Felt that it gave a better sense of privacy and easier to digest than the burrito."
-The alarm was there to alert staff. More effective for elopement risk.
-Field Director #6 and Former Field Director #13 developed the training for the bivy.
-"We got stuff from other programs and then worked the rest of it out on our own."
-If damaged, would call and get a new one. Staff could get a tarp and use the burrito if needed.
-"I don't think explicitly." (tell parents about the bivy)
-"We get them (clients) assessed as soon as possible. It is standard they come in on Assigned proximity and they may change once assessed."
-"If a bivy is a restrictive intervention then so is their sleeping bag."

Interview on 2/21/24 with the Founder/ED revealed:
-Did not do daily operations anymore.
-Supervises the ED.
"If someone is on a heightened watch they are within arms watch at all times."
-"I don't have a lot of first hand knowledge of the bivy system ..."
-"I have been doing this for 30 years. I am aware of licensing standards."
-If equipment is broken, would be expected that they call in and get a replacement.

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Review on 2/16/24 of the Plan of Protection dated 2/16/24 written by the Operations Director revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
Students that are on Assigned Proximity supervision will no longer be in a bivy or burrito sleep arrangement. All students are discharged on Feb 16th.
Describe your plans to make sure the above the happens.
A meeting will discuss + review the least restrictive alternative for students. An alternative policy + procedure will be proposed by March 11th for review."

Clients served by the facility ranged in age from 10 to 17 years old. They had diagnoses including but not limited to, Major Depressive Disorder, ADHD, PTSD, Parent-Child Relational Problem, Generalized Anxiety Disorder, Autism Spectrum Disorder, and Disruptive Mood Dysregulation Disorder. Diagnoses were not received for all clients. Clients had histories of self harm, physical aggression and elopement. The facility implemented a level of supervision that required clients to be within arms length of staff at all times, including during sleep times. The facility began using the bivy system in the fall of 2023 for new admissions and for clients on the highest level of supervision, assigned proximity (AP). Previously the facility used a system known as the burrito or taco. If during the night a client needed to use the bathroom, they would have to ask staff to let them out of the sleeping system they were assigned to while on AP. Using the burrito or taco, staff were sleeping on top of a piece of plastic that was wrapped over/around the clients' body. During the use of these systems,

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clients were not provided dignity or respect as evidenced by having to sleep on the floor of the cabin with a thin sleeping pad, surrounded by plastic that was tied at two ends, while the other clients in the same cabin were able to sleep on bunk beds with mattresses. The staff assigned to sleep within arms reach of staff also slept on a mattress instead of a thin sleeping pad. Also at times, the complete outer shell was zipped up to fully enclose the client inside the bivy. The facility failed to implement their own policies and protocols regarding increased sleeping precautions by not having same sex staff sleep within arms reach of clients at least 23 times between 11-18-23 to 12-28-23 with 5 different clients. The facility's policy on safety levels stated that AP would range between 18 - 72 hours. Eleven clients were also on AP for 72 hours or longer, with 2 of those clients on AP for 72 hours more than once, FC #19 for 2 times and FC #24 for 4 times. The direct care staff could increase levels of supervision, including moving clients up to the AP level but could not move them down. The therapists had control of moving clients off of AP status. The therapists were aware of the bivy system and assigned it, but did not have working knowledge of the bivy system and how it worked or how it was implemented. Parents were not made explicitly aware of the use of the enhanced supervision for sleeping for all new clients at admission. The Founder/ED, who supervised the ED, did not have first hand knowledge of the bivy system. The ED felt the bivy gave a better sense of privacy and easier to digest than the burrito.

This deficiency constitutes a Type B rule violation which is detrimental to the health, safety, and welfare of the clients and must be corrected within 45 days.