

**Statement of Deficiencies
and Plan of Correction**

Inspection begin date 1/26/2010
Inspection end date: 3/30/2010

Name of Provider or Supplier
RIDGE CREEK, INC- MOUNTAIN BROOK ACADEMY

Street Address, City, State Zip Code
830 HIDDEN LAKE ROAD
DAHLONEGA, GA 30533

Inspection Results

R 0000 Opening Comments.

The purpose of this visit was to conduct an investigation into Ga., 77483.

R 0709 290-2-5-.07(d) Inspections and Investigations.

SS=D

Failure to Allow Access. Failure to allow access of the department's representative to the institution, its staff, or the children receiving care at the institution or the books, records, papers, or other information related to initial or continued licens

This Requirement is not met as evidenced by:

Based on a requested record review and staff interview the agency failed to allow acces to the institution's resident case records.

Findings include:

Upon a request by the surveyor to review the facility's residential case records on 1/26/2010 at 11:00 am, the surveyor was told by Staff A that the requested records were not accessible at the time of the inspection due to the agency having technical difficulties with their electronic filing system.

Interview conducted on 1/26/2010 at 5:00 pm with Staff A revealed that their system " Best Note" is down and that all information is stored there.

R 0840 290-2-5-.08(6) Staffing.

SS=D

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Staffing. The institution shall have sufficient numbers of qualified and trained staff as required by these rules to provide for the needs, care, protection, and supervision of children. All staff and volunteers shall be supervised to ensure that assigne

This Requirement is not met as evidenced by:

******Based on file review and staff interview the agency failed to provide for the needs, care, protection, and supervision of children.**

Findings include:

Interview conducted on 1/26/2010 at 11:30 am with Resident #1 revealed that (he/she recalls the incident in question and it began when- on the day of the incident (1/9/2010),) all of the students were in the Student Activity Center (SAC). Resident #1 stated that he/she was approached by Resident #2 who inquired if he/she made a derogatory statement, referencing two other students that are known by all of the students to be "a couple" and whom Resident #1 had written a racial slur on the wall approximately a week prior. Resident #1 stated that as the confrontation continued, a group of other students became involved . (and the argument began to become threatening.- delete) Resident #1 stated that during the argument, Resident #4 approached him/her from behind and "punched him/her in the back of the head twice". Resident #1 reported that Resident #4 was then restrained by staff? and that Resident #2 responded by becoming irate and blocked the exit doorway that staff members were attempting to exit thru with Resident #4. Resident #1 stated that he/she could hear the remaining students "plotting on how to hit him/her" and then Resident #2 began to approach him/her, but "was restrained on the ground by Staff B". Resident #1 reported that Resident #2 accompanied by Resident #3 began to fight Staff B, punching and kicking the staff member in the face and torso area while the remaining group of students attempted to bombard him/her. Resident #1 stated that he/she ran out of the building, slipped on the ice covering the walkway, and fell into some shrubbery. Resident #1 stated that he/she could hear the other resident attempting to follow after him/her; however, Resident #7 "blocked the exit way and instructed him/her to run" . Resident #1 stated that he/she and another student left the area; however, he/she was soon stopped by a group of residents who continued to strike him/her. The other students held them off while he/she locked him/herself in a car until staff members arrived. The police responded shortly afterwards. (Resident #1 stated that upon returning to his/her room, it was discovered that someone had broken his/her electric guitar which he/she estimated to be worth four thousand dollars.- Pam questioned the relevance. I thought you were trying to show that the residents were obviously unsupervised at that time as well to have been able to destroy property in a bedroom, but she felt the connection needed to be made more clear. You can either leave as is, delet or add more)

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Resident #1 stated that he/she received an injury to the eye when hit by Resident #4 and scrapes/scratches from falling into the shrubs. Resident #1 reported that he/she recalls four staff members on duty; however; one had gone to get lunch. Resident #1 stated that staff members did not intervene during the onset of the altercation and only responded once he/she had been struck by Resident #4.

Interview conducted on 1/26/2010 at 12:00 pm with Resident #4 revealed that (he/she recalls the incident in question. Resident #4 stated that - delete) on the day of the incident (1/9/2010), Resident #1 was "being racist" and wrote derogatory statements using inappropriate language in reference to (African Americans- race) . Resident #4 stated that while in the SAC, Resident #1 then verbalized derogatory statements using inappropriate language (in reference to African Americans- regarding race) and that "a group of students got mad and beat Resident #1 up". Resident #4 stated ("staff members- do we know which ones so that we can add their non-identifiers? If not, leave as is) were attempting to contain the situation and deal with all of the other students but that other students ultimately pulled (him/her- use non identifier. unclear if this is referring to staff or resident) away so that Resident #1 would not get beat up that bad". Resident #4 stated that he/she recalls three to four staff members being present at the time of the incident.

Interview conducted on 1/26/2010 at 12:30 pm with Resident #5 revealed that he/she recalls the 1/9/2010 incident (in question- delete) and that "all of the trouble started a few weeks ago when Resident #1 wrote "a racial slur" on the bathroom wall and staff members did not give Resident #1 a consequence for the act. Resident # 5 stated that specifically, the incident in question began when the students were made aware that Resident #1 had made a (verbal- delete) racial slur when Resident #1 and #2 began to argue. Resident #5 reported that a group of students attempted to "fight" Resident #1 and were "able to get a few hits in when Resident #1 ran out of the building". Resident # 5 stated that he/she and a group of other residents attempted to follow, however were stopped by Resident #7, who ultimately "restrained and then drug him/her back into the building. " Is this where the end of quote goes?

Interview conducted on 1/26/2010 at 1:00 pm with Resident #6 revealed that (he/she recalls the incident in question. Resident #6 stated that on the day of the incident (1/9/2010), (he/she- Resident #6?) became involved in a conflict with Resident #1 upon gaining knowledge that Resident # 1 wrote a derogatory statement (towards African Americans- regarding race) on the wall. Resident #6 stated, during this occurrence, he/she confronted Resident #1 about the act and Resident #1 assured him/her that "nothing like that would happen again". Resident #6 stated that on the day of the incident in question, which was approximately a week later,

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Resident #1 verbalized a racial slur directed at two students of different races that are involved in a relationship.

File review conducted on 3/30/2010 of the agency's incident report, dated 1/9/2010, revealed that the incident occurred on 1/9/2010 at approximately 4:00 pm, when staff members heard an argument going on in the movie room of the Student Activity Center (SAC). The report states that Staff members B, C and D observed Resident #1 being confronted by Resident #2, #4, #5, and #6 in regards to "a racist comment that he/she made towards another student". The report states that the students surrounded Resident #1 and that staff members "tried to defuse the situation" when Resident #4 moved behind Resident #1 and "began to repeatedly hit Resident #1 in the head". The report stated that Staff D placed Resident #4 into a "double arm bar restraint" while Resident #1 was escorted by Staff members B and C into the main room of the SAC. The report states that Staff C instructed Resident #1 to leave and go to the dorm, but Resident #1 refused to comply. The report then states that Resident #2 "jumped in front of" Resident #1 and stated that Resident #1 was not leaving. Resident #2 then yelled to Resident #4, #5, and #6 asking "do they have his/her back" and will they participate in assaulting Resident #1. The report continues to describe various efforts employed by Resident #2 to rally residents and instances in which the residents were disobedient and disrespectful to staff members. Ultimately the report states that Staff B got between Resident #1 and #2 and that Resident #2 "shoved Staff B and then slapped Resident #1". The report states that Staff B then "escorted Resident #2 to the ground and that Staff C grabbed his/her legs". The report states that while Staff B attempted "to get into the proper seated double arm bar restraint, Resident #3 "ran up and repeatedly kicked Staff B in his/her face causing his/her lips to split, nose to bleed, and bruising on the forehead". The report states that "other students and Staff D pulled Resident #3 off of Staff B and that Staff C got up to help with the restraint. The report then states that Resident #1 ran out of the front door of the SAC and that Resident #4, #5, #6, and #8 followed after him/her. The report continues to state that Resident #2 attempted to follow and that ultimately Staff B "placed him/her in a standing double arm bar restraint" when Resident #3 intervened and attempted to punch Staff B. The report states that Staff B was able "to dodge the punch and that two other residents restrained Resident #3 "followed by Staff D". The report states that "outside of the dorm, Resident #1 was hit several times in the face; his/her right eye was swollen the next day.

Interview conducted on 1/26/2010 at 5:05 pm., with Staff A revealed that staff to client ratio at the time of the incident was 6 staff members to 40 students. Staff A stated that he/she believes that the number of staff members was suitable; however, he/she believes that staff members reaction to the incident was inappropriate- was it indicated how so? If not, leave as is.). Staff A stated

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that additionally there was "one clinical worker on call that lived on campus and that he/she and another staff member arrived on campus" after being notified of the incident.

R 0861 290-2-5-.08(7) Staffing.

SS=D

Reporting. Detailed written summary reports shall be made to the Department of Human Resources, Office of Regulatory Services, Residential Child Care Unit via email or fax on the required incident intake information form (IIF) within 24 hours.

This Requirement is not met as evidenced by:

Based on file review and staff interview , the agency failed to submit a detailed written summary report to the Department of Human Resources, Office of Regulatory Services, Residential Child Care Unit within 24 hours.

Findings include:

File review conducted on 1/26/2010 at 12:00 pm of the agency's incident report, dated 1/9/2010, revealed that the local county sheriff's office was contacted regarding this incident and as a result Resident #2 and #3 were arrested and detained. The agency did not make a report of the incident to the Department of Human Resources, Office of Regulatory Services, Residential Child Care Unit within 24 hours of its occurrence.

Interview conducted on 1/26/010 at 5:15 pm with Staff A revealed that the agency was not aware that a report was required to be made to the department in connection to police involvement with residents and that he/she was under the impression that charges had to have been filed by the agency.

R 0862 290-2-5-.08(7)(a-g) Staffing.

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SS=D

This [detailed written summary] report shall be made regarding serious occurrences involving children in care, including but not limited to:

- (a) Accidents or injuries requiring medical treatment and/or hospitalization;*
- (b) Death;*
- (c) Suicide attempts;*
- (*

This Requirement is not met as evidenced by:

Based on file review and staff interview, the agency failed to submit a detailed written summary report regarding serious occurrences involving children in care.

Findings include:

File review conducted on 1/26/2010 at 12:00 pm of the agency's incident report, dated 1/9/2010, revealed that the local county sheriff's office was contacted regarding this incident and as a result Resident #2 and #3 were arrested and detained. The agency did not submit a detailed written summary report regarding serious occurrences involving children in care.

Interview conducted on 1/26/010 at 5:15 pm with Staff A revealed that the agency was not aware that a report was required to be made to the department in connection to police involvement with residents and that he/she was under the impression that charges had to have been filed by the agency.

R 1413 290-2-5-.14(1)(d) Behavior Management.

SS=D

Residents shall not be permitted to participate in the behavior management of other residents or to discipline other residents, except as part of an organized therapeutic self-governing program in accordance with accepted standards of practice that is con

This Requirement is not met as evidenced by:

Based on file review and staff interview, residents were allowed to participate in the behavior management of other residents.

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Findings include:

File review conducted on 3/30/2010 of the agency's incident report, dated 1/9/2010, revealed that the incident occurred on 1/9/2010 at approximately 4:00 pm, when staff members heard an argument going on in the movie room of the Student Activity Center (SAC). The report states that Staff members B, C and D observed Resident #1 being confronted by Resident #2, #4, #5, and #6 in regards to "a racist comment that he/she made towards another student". The report states that the students surrounded Resident #1 and that staff members "tried to defuse the situation" when Resident #4 moved behind Resident #1 and "began to repeatedly hit Resident #1 in the head". The report stated that Staff D placed Resident #4 into a "double arm bar restraint" while Resident #1 was escorted by Staff members B and C into the main room of the SAC. The report states that Staff C instructed Resident #1 to leave and go to the dorm, but Resident #1 refused to comply. The report then states that Resident #2 "jumped in front of" Resident #1 and stated that Resident #1 was not leaving. Resident #2 then yelled to Resident #4, #5, and #6 asking "do they have his/her back" and will they participate in assaulting Resident #1. The report continues to describe various efforts employed by Resident #2 to rally residents and instances in which the residents were disobedient and disrespectful to staff members. Ultimately the report states that Staff B got between Resident #1 and #2 and that Resident #2 "shoved Staff B and then slapped Resident #1". The report states that Staff B then "escorted Resident #2 to the ground and that Staff C grabbed his/her legs". The report states that while Staff B attempted "to get into the proper seated double arm bar restraint, Resident #3 "ran up and repeatedly kicked Staff B in his/her face causing his/her lips to split, nose to bleed, and bruising on the forehead". The report states that "other students and Staff D pulled Resident #3 off of Staff B and that Staff C got up to help with the restraint. The report then states that Resident #1 ran out of the front door of the SAC and that Resident #4, #5, #6, and #8 followed after him/her. The report continues to state that Resident #2 attempted to follow and that ultimately Staff B "placed him/her in a standing double arm bar restraint" when Resident #3 intervened and attempted to punch Staff B. The report states that Staff B was able "to dodge the punch and that two other residents restrained Resident #3 "followed by Staff D". The report states that "outside of the dorm, Resident #1 was hit several times in the face; his/her right eye was swollen the next day.

Interview conducted on 1/26/2010 at 5:30 pm with Staff A revealed that he/she acknowledges that "students were involved in the behavior management of other students; however, maintains that the agency does not allow students to participate in the behavioral management of other students."

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R 1420 290-2-5-.14(2)(c)2. Emergency Safety Interventions.

SS=D

Emergency safety interventions policies and procedures shall include: ...

2. Provisions for the documentation of each use of an emergency safety intervention including:

(i) Date and a description of the precipitating incident;

(ii) Description of the

This Requirement is not met as evidenced by:

Based on file review and staff interview the agency failed to document provisions for the documentation of each use of an emergency safety intervention.

Findings include:

A file review conducted of the agency's incident report, dated 1/9/2010, indicated that emergency safety interventions were carried out on several residents; however, there was no provision for the documentation (on the provisions - delete) for each use.

File review conducted on 3/30/2010 of the agency's incident report, dated 1/9/2010, revealed that the incident occurred on 1/9/2010 at approximately 4:00 pm, when staff members heard an argument going on in the movie room of the Student Activity Center (SAC). The report states that Staff members B, C and D observed Resident #1 being confronted by Resident #2, #4, #5, and #6 in regards to "a racist comment that he/she made towards another student". The report states that the students surrounded Resident #1 and that staff members "tried to defuse the situation" when Resident #4 moved behind Resident #1 and "began to repeatedly hit Resident #1 in the head". The report stated that Staff D placed Resident #4 into a "double arm bar restraint" while Resident #1 was escorted by Staff members B and C into the main room of the SAC. The report states that Staff C instructed Resident #1 to leave and go to the dorm, but Resident #1 refused to comply. The report then states that Resident #2 "jumped in front of" Resident #1 and stated that Resident #1 was not leaving. Resident #2 then yelled to Resident #4, #5, and #6 asking "do they have his/her back" and will they participate in assaulting Resident #1. The report continues to describe various efforts employed by Resident #2 to rally residents and instances in which the

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residents were disobedient and disrespectful to staff members. Ultimately the report states that Staff B got between Resident #1 and #2 and that Resident #2 "shoved Staff B and then slapped Resident #1". The report states that Staff B then "escorted Resident #2 to the ground and that Staff C grabbed his/her legs". The report states that while Staff B attempted "to get into the proper seated double arm bar restraint, Resident #3 "ran up and repeatedly kicked Staff B in his/her face causing his/her lips to split, nose to bleed, and bruising on the forehead". The report states that "other students and Staff D pulled Resident #3 off of Staff B and that Staff C got up to help with the restraint. The report then states that Resident #1 ran out of the front door of the SAC and that Resident #4, #5, #6, and #8 followed after him/her. The report continues to state that Resident #2 attempted to follow and that ultimately Staff B "placed him/her in a standing double arm bar restraint" when Resident #3 intervened and attempted to punch Staff B. The report states that Staff B was able "to dodge the punch and that two other residents restrained Resident #3 "followed by Staff D". The report states that "outside of the dorm, Resident #1 was hit several times in the face; his/her right eye was swollen the next day.

Interview conducted on 1/26/2010 at 5:35 pm with Staff A revealed that he/she acknowledges that there was no documentation of the identified emergency safety interventions described.

R 9999 Closing Comments.

This visit was concluded with an exit conference. A preliminary inspection report was submitted to the agency on 4/12/2010. A plan of correction is due ten days after receipt of the survey.