Statement of Deficiencies and Plan of Correction	Inspection begin date 6/28/2010 Inspection end date: 7/21/2010
Name of Provider or Supplier RIDGE CREEK, INC	Street Address, City, State Zip Code 830 HIDDEN LAKE RD DAHLONEGA, GA 30533

Inspection Results

R 0000 Opening Comments.

The purpose of this survey is to conduct an investigation for self reported incident #GA00083346.

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

SS=G

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 record review and staff interview, the agency failed to have sufficient numbers of trained staff to provide for the protection of children in care.**

Findings include

Review on 6/28/2010 at 4:00 pm of Resident #1's incident report, dated 6/10/2010, revealed that at 9:15 pm, Staff A went into Resident #1's room to talk with him/her about some issues Resident #1 has been struggling with throughout the day. This report indicated that Resident #1 was sitting at the computer with another resident and Staff A began questioning Resident #1. This report stated that at this time Resident #1 picked up the computer and threw it against the wall. The report indicated that Resident #1 then proceeded to pick up his/her chair and broke the glass window. This report revealed that Staff A proceeded to direct Resident #1 outside to where he/she could calm down and regain his/her thoughts. The report then stated that Resident #1 said he/she was not going outside until he/she dealt with something first. The report went on to state that Resident #1 got up and ran to a room where Resident #2 was located, which was down the hall in this dorm. This report stated that Resident #1 and #2 began fighting. According to this report other residents began to jump in by punching and kicking Resident #1. Staff A wrote that other staff attempted to break up the fight and was assisted by Staff B.

Review on 6/28/2010 at 4:00 pm of Staff A's training, revealed that on April 28-30, 2010 he/she received full certification in Therapeutic Aggression Control Techniques-2 (TACT-2). Staff A's date of hire was 3/15/2010.

Statement of Deficiencies and Plan of Correction	Inspection begin date 6/28/2010 Inspection end date: 7/21/2010
Name of Provider or Supplier RIDGE CREEK, INC	Street Address, City, State Zip Code 830 HIDDEN LAKE RD DAHLONEGA, GA 30533

Inspection Results

Review on 6/28/2010 at 4:00 pm of Staff B's training, revealed that on April 28-30, 2010, he/she received verbal certification on TACT 2. Staff B's date of hire was 1/29/2010.

Review on 6/28/2010 at 4:00 pm of Staff C's file, revealed that he/she has not been trained on any emergency safety interventions. Staff C's date of hire was 6/1/2010.

Interview with Staff D was conducted on 6/28/2010 at 3:46 pm. Staff D stated that Staff B did complete the full TACT-2 training, but received verbal certification because she/he has a smaller stature than the residents.

Interview with Staff A was conducted on 6/28/2010 at 2:15 pm. Staff A reported that the incident happened on 6/10/2010. Staff A said he/she was coming in the dorms around 9:15 pm and was going to follow up with Resident #1 as he/she requested earlier for another issue. Staff A reported that Resident #1 was sitting at his/her computer and talking with another resident. Staff A said Resident #1 was crying and picked up the computer and pushed it away. Staff A said he/she offered to speak with Resident #1, but Resident #1 refused. Staff A said Resident #1 then picked up a chair and said "not until I finish some business." Staff A said Resident #1 then threw the chair against the window causing it to shatter. Staff A went on to state that Resident #1 ran out of his/her room towards Resident #2's room. Staff A said Resident #1 was screaming and running causing residents to look. Staff A said when he/she got to the room there was Resident #1 and #2. Staff A said he/she arrived in the room the same time Resident #3 and #4 entered. Staff A reported that there was a split second where it was just Resident #1 and #2 alone in the room, so he/she was able to pull Resident #2 to the side. Staff A said Resident #1 was on the floor when Resident #3 and #4 started kicking Resident #1. Staff A then stated that he/she was trying to cover Resident #1 and deflect as many of the kicks as possible. Staff A said about 10 seconds after he/she arrived in the room, Staff C entered; however, Staff C wasn't able to assist as much because he/she was not trained in emergency safety interventions. Staff A said Resident #1 received about 10-15 kicks to the face and blood was everywhere. Staff A then reported that Resident #3 pushed Staff C to the side. Staff A recalled that Staff B came in the room right after Staff C. Staff A stated that Resident #4 pushed Staff B through a crowd of residents that were outside the room blocking the entrance. Staff A then reported that Staff B was able to get back up and restrain Resident #4. Staff A said when Resident #4 was restrained, he/she could be heard and got the residents to leave the area. Staff A said Staff B was able to get the aggressors out of the room. Staff A said he/she walked Resident #1 out of the room and and took Resident #1 to the emergency room with Staff B. Staff A stated that Staff C was on his/her second day of work, so he/she was trying to get the residents away, but did not restrain anyone. Staff A indicated that Resident #1 had a broken nose, 2 chipped teeth, but no concussion. Staff A recalled that there

Statement of Deficiencies and Plan of Correction	Inspection begin date 6/28/2010 Inspection end date: 7/21/2010
Name of Provider or Supplier RIDGE CREEK, INC	Street Address, City, State Zip Code 830 HIDDEN LAKE RD DAHLONEGA, GA 30533

Inspection Results

were about 15 residents present in the doorway at the time of the incident. Staff A reported that at the time of the incident there were 29 residents total, including the ones that were fighting, and three staff members on duty for that dorm.

Interview with Resident #1 was conducted on 6/28/2010 at 2:42 pm. Resident #1 reported that at the beginning of the day he/she had a fight with another resident that day, who was later picked on by Resident #5. Resident #1 said she/he told his/her counselor about the issue and the counselor spoke with Resident #5. Resident #1 said later that day Resident #2 came to his/her room and threatened him/her. Resident #1 said he/she got angry and ran down the hall to Resident #2's room. Resident #1 said they started fighting and all he/she can remember is being attacked by others. Resident #1 said Staff A was trying to keep Resident #2 off of him/her, while Staff B was trying to enter the room. Resident #1 stated that some residents blocking the door. Resident #1 said residents were hitting him/her. Resident #1 said he/she went to the hospital and was diagnosed with a broken nose and swelling. Resident #1 said Staff A and B took him/her to the emergency room. Resident #1 said he/she blacked out a little when he/she was hit to the head. Resident #1 reported that staff knew he/she was getting angry throughout the day, but Staff A did what he/she could. Resident #1 said he/she told his/her counselor that day that he/she was being antagonized by Resident #5. Resident #1 said he/she thinks that Staff A knew about the problems he/she was having and that's why Staff A came to the room to talk. Resident #1 said Staff C didn't get in the room, but Staff B was trying to keep people out of the room.

Interview with Staff C was conducted on 6/28/2010 at 3:00 pm. Staff C said on June 10th, he/she noticed something was going on when Resident #1 broke a window. Staff C said Staff A was with Resident #1. Staff C said he/she was floating around the dorms when he/she heard yelling. Staff C said Resident #2 was in the hallway when Resident #1 made it into Resident #2's room. Staff C said it was a "mad rush" between residents and staff going to the room. Staff C said when he/she made it in the room, he/she saw Resident #2, #3, and #4 beating on Resident #1. Staff C stated that he/she grabbed the shoulder of Resident #3 while Staff A was shielding Resident #1. Staff C said Resident #3 was able to break free and kick Resident #1. Staff C said Staff B came in the room after having some trouble entering due to residents blocking the doorway. Staff C said Staff B was able to get Resident #4 to leave the room. Staff C said he/she didn't know the cause of the fight and did not know there was tension going on that day. Staff C said he/she was with a group of residents earlier that day when Resident #1 accidentally hit one of the residents with a stick. Staff C said he/she was told later that this was the cause of the tension throughout the day. Staff C recalled that there were approximately 27-30 residents present on the day of the incident and there were 4 staff members assigned to that dorm. Staff C said he/she is not sure if all four staff members were present, but one could have been administering medication at that time.

Statement of Deficiencies and Plan of Correction	Inspection begin date 6/28/2010 Inspection end date: 7/21/2010
Name of Provider or Supplier RIDGE CREEK, INC	Street Address, City, State Zip Code 830 HIDDEN LAKE RD DAHLONEGA, GA 30533

Inspection Results

Interview with Resident #2 was conducted on 6/28/2010 at 3:15 pm. Resident #2 stated that he/she doesn't feel like staff did their job, because it took staff 5 minutes to intervene with the fight. Resident #2 reported that Resident #1 started the fight by coming after him/her. Resident #2 said Resident #1 charged at him/her and there was no staff around. Resident #2 said Resident #1 struck first and he/she doesn't remember what happened next. Resident #2 said he/she doesn't remember how the fight ended because he/she "pretty much blacked out."

Interview with Resident #4 was conducted on 6/28/2010 at 3:25 pm. Resident #4 did report that staff could have done more because they knew Resident #1 was "heated" that day, but they just let everything unfold.

Interview with Resident #3 was conducted on 6/28/2010 at 3:29 pm. Resident #3 stated that the day of the incident his/her roommate, Resident #5, came to him/her and said he/she was afraid that Resident #1 would kill him/her. Resident #3 said later that night he/she and Resident #2 asked Resident #1 why was he/she threatening Resident #5. Resident #3 said he/she was in Resident #4's room when he/she heard a crash and screaming. Resident #3 said he/she saw Resident #1 run by the room. Resident #3 said someone said that Resident #1 just broke a window and was trying to attack Resident #2. Resident #3 said Resident #2 is one of his/her best friends and he/she thought about Resident #1's threats to others. Resident #3 said he/she was afraid that Resident #1 would injure Resident #2. Resident #1 said he/she was thinking that Resident #1 had a piece of glass from the broken window. Resident #3 then admitted that he/she pushed Resident #1 away from Resident #2 and Resident #1 turned around and hit him/her. Resident #3 said he/she got angry and hit Resident #1 multiple times. Resident #3 said staff intervened when Resident #1 was on the floor knocked out. Resident #3 said Staff B was watching at the door, and Staff C had his/her arm around Resident #3's body. Resident #3 said his/her arms were by his/her side in the hold by Staff C. Resident #3 indicated he/she stopped fighting at that point. Resident #3 said it could have been prevented because staff knew Resident #1 was angry that day. Resident #3 said the counselor talked with Resident #5 and told him/her that Resident #1 threatened to kill him/her. Resident #3 said he/she is not sure how many staff members were present this day or how long it took Staff A to enter the room.

Interview with Staff B was conducted on 6/29/2010 at 2:50 pm. Staff B reported that all day there were rumors about Resident #1 wanting to beat up Resident #5 and that Resident #5's friends went into Resident #1's room and asked why he/she was threatening Resident #5. Staff B reported that Resident #1 got angry and Staff A tried to speak with Resident #1. Staff B indicated that Resident #1 threw a chair at the window and Staff B was standing in the doorway. Staff B

Statement of Deficiencies and Plan of Correction	Inspection begin date 6/28/2010 Inspection end date: 7/21/2010
Name of Provider or Supplier RIDGE CREEK, INC	Street Address, City, State Zip Code 830 HIDDEN LAKE RD DAHLONEGA, GA 30533

Inspection Results

said Resident #1 then came out of the room forcefully and pointed at Resident #2. Staff B indicated that Resident #1 and #2 went into the room and Staff A and B ran down the hallway after them. Staff B said the other residents were there and Staff B stood over Resident #1. Staff B reported that Resident #3 and #4 were in the room kicking Resident #1. Staff B said she/he went behind Resident #4 and took him/her by the arm. Staff B said Resident #4 left the room. Staff B said she/he doesn't know what Staff C was doing because everything happened so quickly. Staff B said she/he doesn't think that Staff C physically restrained anyone. Staff B said she/he did not use a TACT2 restraint, she/he just took Resident #4 by the arm to escort out the room. Staff B said Resident #4 wasn't fighting back. Staff B said Resident #4 was the only one she/he physically touched. Staff B reported that Resident #4 is his/her size and has a good rapport with him/her, so it was easier to get Resident #4 out of the room. Staff B said Resident #3 followed and then Resident #2 exited the room. Staff B said Staff A got Resident #1 out of the room. Staff B indicated that there were about 35 residents total in the dorm this day. Staff B said there were 3 staff members in the room. Staff B said one staff member was administering medication with about 10 other residents. Staff B said 2 hours before the actual fight, a resident approached a counselor and said it might be a fight and Resident #1 should be monitored. Staff B said Resident #1's counselor told the leader of the reflections group (where Resident #1 was located at the time). Staff B said the group leader sent Resident #5 off campus to keep his/her separated from Resident #1. Staff B reported that Staff A was waiting to speak with Resident #1 after the reflections group. Staff B reported that Resident #1 was supervised close that day, but by the time he/she got into the dorms he/she was beyond calming. Staff B reiterated that one staff member was dispensing medication at the time of the fight and one staff member was monitoring the residents that were waiting for medication. Staff B said she/he did not have to physically restrain anyone. Staff B stated that the ratio is typically 4 staff to 30 residents, but sometimes there are just 3 staff members. Staff B said as far as she/he knew, staff was talking about monitoring Resident #1 that day. Staff B said she/he was standing in the doorway of the room when Resident #1 came out forcefully, but due to the size difference, she/he moved and could only follow Resident #1. Staff B said the incident happened fast and the residents moved toward the room quickly. Staff B said the residents wouldn't move and hs/he had to push his/her way through the door to enter the room. Staff B said the fight started about 30 seconds before she/he entered the room.

Statement of Deficiencies and Plan of Correction	Inspection begin date 6/28/2010 Inspection end date: 7/21/2010
Name of Provider or Supplier RIDGE CREEK, INC	Street Address, City, State Zip Code 830 HIDDEN LAKE RD DAHLONEGA, GA 30533

Inspection Results

R 1003 290-2-5-.10(b) Assessment and Planning.

SS=C

A service and room, board and watchful oversight plan shall be developed by the child's Human Services Professional in concert with the child's primary Child Care Worker, meaning the worker who has responsibility for supervision of the child in the living

This Requirement is not met as evidenced by:

Based on record review and staff interview, the agency failed to have completed Service, Room, Board, and Watchful Oversight plans to include activities to be followed by staff in pursuit of stated goals and objectives for two of four plans reviewed.

Findings Include

Review on 6/28/2010 at 4:00 pm of Resident #1's Individual Service Plan, dated 5/11/2010, revealed that the plan did not include activities to be followed by staff in pursuit of stated goals and objectives. Resident #1 was admitted nearly two months ago.

Review on 6/28/2010 at 4:00 pm of Resident #4's Individual Service Plan, dated 2/11/2010, revealed that the plan did not include activities to be followed by staff in pursuit of stated goals and objectives. Resident #4 was admitted nine months ago.

During interview with Staff D on 6/28/2010 at 4:56 pm, he/she acknowledged the findings.

This rule was previously cited on 12/10/2009 and 12/3/2008.

Statement of Deficiencies and Plan of Correction	Inspection begin date 6/28/2010 Inspection end date: 7/21/2010
Name of Provider or Supplier RIDGE CREEK, INC	Street Address, City, State Zip Code 830 HIDDEN LAKE RD DAHLONEGA, GA 30533

Inspection Results

R 1011 290-2-5-.10(d) Assessment and Planning.

SS=F

The service and room, board and watchful oversight plan shall be updated by the Human Services Professional at a minimum of every six months and pertinent progress notes and data shall be incorporated in the plan to measure attainment of stated goals and

This Requirement is not met as evidenced by:

******Based on record review and staff interview, the agency failed to ensure that the Service Room, Board, and Watchful Oversight Plan is updated by the Human Services Professional at a minimum of every six months for one of four files reviewed.**

Findings Include

Review on 6/28/2010 at 4:00 pm of Resident #2's individual Service Plan, dated 10/30/2009, revealed that the plan is outdated. Resident #2 was admitted over eight months ago.

During interview with Staff D on 7/16/2010 at 2:42 pm, he/she acknowledged the findings after he/she checked the agency's data base for the current plan.

This rule was previously cited on 12/10/2009 and 12/3/2008.

R 1402 290-2-5-.14(1)(b)2. Behavior Management.

SS=D

Such Behavior management policies and procedures shall incorporate the following minimum requirements: ...

Statement of Deficiencies and Plan of Correction	Inspection begin date 6/28/2010 Inspection end date: 7/21/2010
Name of Provider or Supplier RIDGE CREEK, INC	Street Address, City, State Zip Code 830 HIDDEN LAKE RD DAHLONEGA, GA 30533

Inspection Results

2. Behavior management shall be limited to the least restrictive appropriate method, as described in the child's service plan pursuant to Rule

This Requirement is not met as evidenced by:

Based on record review and staff interview, the agency failed to ensure that behavior management is limited to the least restrictive appropriate method, as described in the child's Room, Board, and Watchful Oversight Plan and in accordance with the prohibitions as specified in the rules and regulations.

Findings Include

Interview with Resident #2 was conducted on 6/2820/2010 at 3:15 pm. Resident #2 said he/she doesn't remember what happened during the incident, but he/she knows that he/she was in a fight. When asked if he/she received a consequence for fighting, Resident #2 indicated that staff sent him/her to the wilderness intervention program for 8 days.

Review on 6/28/2010 at 4:00 pm of Resident #2's Individual Service Plan, dated 10/30/2009, did not reveal that the wilderness intervention program would be used as a behavioral management method.

Interview with Resident #4 was conducted on 6/28/2010 at 3:25 pm. When asked if he/she received a consequence for involvement with the physical altercation, Resident #4 said first staff spoke with him/her then he/she was sent to the wilderness intervention program for 8 days. Resident #4 reported that the wilderness program is not on campus. It consists of a tavern and the residents sleep on wooden boards.

Review on 6/28/2010 at 4:00 pm of Resident #4's Individual Service Plan, dated 2/11/10, did not reveal that the wilderness intervention program would be used as a behavioral management method.

Interview with Resident #3 was conducted on 6/28/2010 at 3:29 pm. Resident #3 stated that on 6/10/2010, Resident #5 came to him/her and said he/she was afraid that Resident #1 would kill him/her. Resident #3 said later that night he/she and Resident #2 asked Resident #1 why was he/she threatening Resident #5. Resident #3 said he/she was in Resident #4's room when he/she heard a crash and screaming. Resident #3 said he/she saw Resident #1 run by the room. Resident #3 said someone said that Resident #1 just broke a window and was trying to attack

Statement of Deficiencies and Plan of Correction	Inspection begin date 6/28/2010 Inspection end date: 7/21/2010
Name of Provider or Supplier RIDGE CREEK, INC	Street Address, City, State Zip Code 830 HIDDEN LAKE RD DAHLONEGA, GA 30533

Inspection Results

Resident #2. Resident #3 said Resident #2 is one of his/her best friends and he/she thought about Resident #1's problems and remembered Resident #1 threatened others. Resident #3 said he/she was afraid that Resident #1 would injure Resident #2. Resident #1 said he/she was thinking that Resident #1 had a piece of glass from the broken window. Resident #3 then admitted that he/she pushed Resident #1 away from Resident #2 and Resident #1 turned around and hit him/her. Resident #3 said he/she got angry and hit Resident #1 multiple times. Resident #3 said he/she was sent to the wilderness intervention program and slept on a flat sheet of wood. Resident #3 said he/she was in the wilderness intervention program for 1 week.

Review on 6/28/2010 at 4:00 pm of Resident #3's Individualized Service Plan, dated 4/1/2010, did not reveal that the wilderness intervention program would be utilized as a behavioral management method.

During interview with Staff D on 6/28/2010 at 3:46 pm, Surveyor asked about the wilderness intervention program. Staff D reported that wilderness intervention is used as a behavior management technique.

Review on 6/28/2010 at 5:00 pm of the agency's Wilderness Intervention Curriculum, revealed a form labeled "Odds and Ends". This form states the following: "Students are responsible for maintaining their gear, equipment, and personal hygiene. If students break, lose, or do not maintain equipment--they may have to do without (Stay within policies and procedures, and safety). Keep wilderness student off main campus. No student is allowed in the shelter until completion of Solo." This form also indicates that tents are utilized.

Review on 6/28/2010 at 5:00 pm of the agency's Wilderness Initiative Daily Schedule, revealed examples of rewards given to residents which includes: extra sleeping pad, pillows. The schedule dated May 3, 2010 indicates the following: "solo starts at 9:00 pm, students can only communicate with staff, journal about life goals, and objectives."

Cross reference Tag 840

Statement of Deficiencies and Plan of Correction	Inspection begin date 6/28/2010 Inspection end date: 7/21/2010
Name of Provider or Supplier RIDGE CREEK, INC	Street Address, City, State Zip Code 830 HIDDEN LAKE RD DAHLONEGA, GA 30533

Inspection Results

R 1808 290-2-5-.18(2)(c) Physical Plant and Safety.

SS=D

Each child shall be provided his or her own personal bed and mattress that is no shorter than the child's height and at least thirty inches wide. Clean sheets, pillows and pillow cases, blankets or bed covering shall be provided and sheets and pillow case

This Requirement is not met as evidenced by:

Based on record review and staff interview, the agency failed to ensure that each child shall be provided his/her own personal bed and mattress with pillows, blankets or bed covering.

Findings Include

Review on 6/28/2010 at 5:00 pm of the agency's Wilderness Initiative Daily Schedule, revealed examples of rewards given to residents which includes extra sleeping pad and pillows.

Interview with Resident #4 was conducted on 6/28/2010 at 3:25 pm. When asked if he/she received a consequence for involvement with the physical altercation, Resident #4 said that first staff spoke with him/her then he/she was sent to the wilderness intervention program for 8 days. Resident #4 reported that the wilderness program is not on the campus. It consists of a tavern and the residents sleep on wooden boards.

Interview with Resident #3 was conducted on 6/28/2010 at 3:29 pm. Resident #3 stated that on 6/10/2010, he/she pushed Resident #1 away from Resident #2 and Resident #1 turned around and hit him/her. Resident #3 said he/she got angry and hit Resident #1 multiple times. Resident #3 said he/she was sent to the wilderness intervention program as his/her consequence and slept on a flat sheet of wood. Resident #3 said he/she was in the wilderness intervention program for 1 week.

R 9999 Closing Comments.

Statement of Deficiencies and Plan of Correction	Inspection begin date 6/28/2010 Inspection end date: 7/21/2010
Name of Provider or Supplier RIDGE CREEK, INC	Street Address, City, State Zip Code 830 HIDDEN LAKE RD DAHLONEGA, GA 30533

Inspection Results

An exit conference was conducted onsite. There was one rule violation related to self reported incident #GA00083346. There were four rule violations found during the investigation. The preliminary report was mailed on 7/12/2010. The plan of correction is due ten days after the receipt of this report.