ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

# RED HAWK BEHAVIORAL HEALTH, LLC

**Behavioral Health Residential Facility**

See key licensing information currently on file with the Arizona Department of Health Services below. If applicable, click on the license # to view the currently effective license.

**Legal Name**
RED HAWK BEHAVIORAL HEALTH, LLC

**Address**
3767 South Scenic Boulevard, Littlefield, AZ 86432

**Accreditation**
The Joint Commission (TJC)

**Phone**
4352365424

**Maximum Licensed Capacity**
24

**Behavioral Health Professional**
Glen Horlacher

**Chief Administrative Officer**
VALERIE FAAOOTOA

**Facility Type**
Behavioral Health Residential Facility

**Facility Type Description**
A health care institution that provides treatment to an individual experiencing a behavioral health issue that: a. limits the individual's ability to be independent, or b. causes the individual to require treatment to maintain or enhance independence.

**Additonal Information**
BH Residential Facility - Child

**Facility Status**
Closed ⓘ

**License Status**
Expired ⓘ

**License**
BH5273

**License Effective**
10/1/2023

**Closed Date**
9/11/2025

**Owner / Licensee**
RED HAWK BEHAVIORAL HEALTH, LLC

# 7/23/2025 Inspection

**Inspection #**
INSP-0136480

**Inspection Date(s)**
7/23/2025

**Status**
Enforcement

**Inspection Type**
Complaint

**Location Type**

**Worksheet Type**
Behavioral Health Residential Facility

**Certificate Number**
BH5273

**Initial Comments**
The following the deficiencies were found during the on-site investigation of complaint 00137080 conducted on July 23, 2025:

## Statement of Deficiency

| Rule | Evidence |
|---|---|
| A.R.S. § 36-407.A. Prohibited acts; required acts<br>A. A person shall not establish, conduct or maintain in this state a health care institution or any class or subclass of health care institution unless that person holds a current and valid license issued by the department specifying the class or subclass of health care institution the person is establishing, conducting or maintaining. The license is valid only for the establishment, operation and maintenance of the class or subclass of health care institution, the type of services and, except for emergency admissions as prescribed by the director by rule, the licensed capacity specified by the license. | Based on documentation review, observation and interview, the administrator failed to ensure the behavioral health residential facility did not establish, conduct or maintain in this state a health care institution or any class or subclass of health care institution unless that person holds a current and valid license issued by the department specifying the class or subclass of health care institution the person is establishing, conducting or maintaining. The license is valid only for the establishment, operation and maintenance of the class or subclass of health care institution and the type of services. The deficient practice posed a risk as a behavioral health residential subclass is not authorized to provide continuous nursing services.<br>Findings include:<br>1. A review of the website "https://azbn.gov/sites/default/files/AO-Ketamine-Administration.pdf" from the Arizona State Board of Nursing stated the following: "Registered Nurse - a. Only RNs who have completed an instructional program and have had supervised clinical practice can administer Ketamine. b. Specific |

requirements related to route/purpose of administration: i. RNs must follow the Sedation: Deep, Moderate, and Palliative advisory opinion. ii. Specific orders for titration including dose and assessment via validated scale iii. If utilizing IV Ketamine, RNs may adjust the rate of infusion per a patient-specific order only.sdf c. Orders need to be individualized, and based upon the patient-specific needs with a medical rationale for the order. Issuing standing orders for Ketamine by an APRN for a nurse or other healthcare staff member to follow contradicts the Arizona State Board of Nursing's 2017 Advisory Opinion regarding standing orders, and does not satisfy the APRN's duties to the patient. d. RNs have the right and obligation to refuse to administer continuous IV Ketamine infusion that may induce moderate or deep sedation or anesthesia when the intent is for chronic pain or depression. e. Minimum monitoring requirements include pulse oximetry, vital signs and level of sedation, adverse reactions.:

2. A review of the Arizona State Board of Nursing website revealed "Orders need to be individualized, and based upon the patient-specific needs with a medical rationale for the order. Issuing standing orders for Ketamine by an APRN for a nurse or other healthcare staff member to follow contradicts the Arizona State Board of Nursing's 2017 Advisory Opinion regarding standing orders, and does not satisfy the APRN's duties to the patient. "

3. The Compliance Officers observed a checklist posted in a front office. The checklist stated "Facilitate Ketamine pre dosing and vitals-Administer Ketamine and monitor vitals-Post Ketamine therapy vitals."

4. The Compliance Officers requested to review medication orders for any residents who had received Ketamine, per the aforementioned checklist. However, medication orders were not provided for review.

5. A review of facility documentation revealed the following: a photograph taken of what appeared to be five medication containers. The containers were for C-Ketamine Troche C and stated the following: For R1 - "(100 MG) - Dissolve 1/2-1 Troche as directed for Ketamine Assisted Therapy," For R2 - "100 MG - Dissolve 1/2-1 Troche under the tongue during therapy," For R4 - "(100 MG) - Dissolve 1 - 1&1/2 Troches under the tongue for Ketamine Assisted Therapy," For R10 - "(100 MG) - Dissolve 1/2-1 Troche as directed for Ketamine Assisted Therapy," and For R11 - "(100 MG) - Dissolve 1/2-1 Troche as directed for Ketamine Assisted Therapy."

6. In an interview, R2 stated R2 had taken Ketamine and "was not a fan." R2 reported R2 had received Ketamine four times, in January and March 2025 and two other times, dates unknown. R2 reported the Ketamine was given to R2 by [E6] then R2 would go into therapy session with [E2.] R2 stated feeling "out of it and drunk" and reported R2 refused to take Ketamine again in the future.

7. In an interview, R4 reported R4 had taken Ketamine last May. R4 stated [E6] gave R4 the Ketamine and the Ketamine dissolved under R4's tongue. R4 stated R4 "felt weird and out of control" after taking Ketamine. R4 stated R4 was told R4 was given Ketamine so R4 would "open up and speak freely after taking it." R4 reported R4 did not want to take Ketamine again because of the way Ketamine made R4 feel.

8. In an interview, E12 reported E12 prescribed Ketamine to several residents. E12 reported the Ketamine was given (by E6) via assistance in the self-administration of medications, with a blood pressure medication and vitals were taken before and after (by E6) the individual resident therapy sessions (conducted with E2.)

9. In an exit interview, the findings were discussed with E1, E2 and E3. E2 acknowledged residents participated in Ketamine-assisted therapy. The Arizona

State Board of Nursing requirements for a Registered Nurse were read to E1, E2 and E3. E2 reported the practice of Ketamine-assisted therapy was a common practice and an acceptable/known treatment for children. No additional comments or documentation were provided.

## Statement of Deficiency

### Rule

A.R.S. § 36-425.03.E. Children's behavioral health programs; personnel; fingerprinting requirements; exemptions; definitions
E. Children's behavioral health program personnel shall certify on forms that are provided by the department and notarized that they are not awaiting trial on or have never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction.

### Evidence

Based on record review and interview, the children's behavioral health program personnel failed to certify on forms that were provided by the department and notarized that they were not awaiting trial on or have never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction for eleven of eleven personnel members sampled. The deficient practice posed a risk if the sampled personnel members were a a danger to a vulnerable population.

Findings include:

1.A review of eleven personnel records revealed no documentation to demonstrate any Department-provided forms were completed and notarized as to the personnel members awaiting trial or being convicted of any offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction.

2.In an interview, E3 reported to be unaware of this requirement.

3.In an exit interview, the findings were reviewed with E1, E2 and E3 and no additional comments or documentation were provided.

## Statement of Deficiency

### Rule

R9-10-703.M.1-3. Administration

M. An administrator shall ensure that the following information or documents are conspicuously posted on the premises and are available upon request to a personnel member, employee, resident, or a resident's representative:

1. The behavioral health residential facility's current license,
2. The location at which inspection reports required in R9-10-720(C) are available for review or can be made available for review, and
3. The calendar days and times when a resident may accept visitors or make telephone calls.

### Evidence

Based on observation and interview, the administrator failed to ensure the following information or documents were conspicuously posted on the premises: the calendar days and times when a resident may accept visitors or make telephone calls.

Findings include:

1.The Compliance Officers observed no posting of the calendar days and times when a resident may accept visitors or make telephone calls.

2.In an interview, E3 acknowledged there was no conspicuously posting of the calendar days and times when a resident may accept visitors or make telephone calls.

3.In an exit interview, E1 and E2 asked E3 if there was a posting of the calendar days when a resident was able to accept visitors or make telephone calls and E3 reported that no posting existed.

## Statement of Deficiency

### Rule

R9-10-703.N.1. Administration

N. An administrator shall ensure that:

1. Labor performed by a resident for the behavioral health residential facility is consistent with A.R.S. § 36-510;

### Evidence

Based on documentation review, record review, and interview, the administrator failed to ensure labor performed by a resident for the behavioral health residential facility was consistent with A.R.S. § 36-510, for five of ten residents sampled. The deficient practice posed a possible exploitation risk.

Findings include:

A.R.S. § 36-510 states, "If a patient of a mental health treatment agency works, this work shall be in the patient's interest. If the primary purpose of this work is to benefit the mental health treatment agency or any agency of the state, the patient shall be employed and paid in accordance with law. If the purpose of the work is therapeutic, the patient may or may not be paid as circumstances indicate. This therapeutic work shall be part of a planned program of treatment described in the patient's record with the rationale for the work-treatment included. It shall be periodically reviewed by the appropriate agency review procedures. The term "work" does not mean matters of personal housekeeping or personal maintenance."

1.A review of the facility's policies and procedures revealed an undated document titled, "Program Philosophy," which stated, "We commit to provide...the encouragement of work when appropriate."

2.A review of the facility's policies and procedures revealed an undated document titled, "Level System," which stated, "...Pre-Team...Procedure: Skills that are focused on are:...Work hours/Restitution..."

3.A review of documentation revealed an undated document titled, "General House Rules," which included a section titled, "Youth Rights." The document stated, "...Each youth has the right:...To have adequate compensation for work..."

4.A review of R1's medical record revealed an undated document titled, "Psychotherapy Treatment Plan," dated in January of 2024. However, the treatment plan did not include any documentation therapeutic work shall be part of a planned program of treatment for R1, including the rationale for the work-treatment.

5.A review of R2's medical record revealed a document titled, "Psychotherapy Treatment Plan," dated in June of 2023. However, the treatment plan did not include any documentation therapeutic work shall be part of a planned program of treatment for R2, including the rationale for the work-treatment.

6.A review of R3's medical record revealed a document titled, "Psychotherapy Treatment Plan," dated in August 2024 (admission date in July of 2025). The treatment plan stated, "Goal: Develop strategies to reduce episodes of dysregulation and harmful behavior...4. Learn to control self talk and manage anger, sadness and anxiety by participating in daily milieu activities, work projects, service projects, and paid working projects..." and did not include the rationale for the work-treatment.

7.A review of R5's medical record revealed a document titled, "Psychotherapy Treatment Plan," dated in September of 2024. The treatment plan stated, "Goal: Develop strategies to reduce episodes of dysregulation and harmful behavior...4. Learn to control self talk and manage anger, sadness and anxiety by participating in daily milieu activities, work projects, service projects, and paid working projects..." and did not include the rationale for the work-treatment.

8.A review of R10's medical record revealed a document titled, "Psychotherapy Treatment Plan," dated in September of

2023. However, the treatment plan did not include any documentation that therapeutic work shall be part of a planned program of treatment for R10, including the rationale for the work-treatment.

9.A review of documentation revealed a resident work log notebook. The notebook included a page for R1 that documented a tally of money R1 earned for work they did and any money spent at outside activities. R1's page documented earning $20 per day for "cleaning apartment" on June 6, 13, and 15, 2025 and July 13, 2025.

10.A review of documentation revealed a resident work log notebook. The notebook included a page for R2 that documented a tally of money R2 earned for work they did and any money spent at outside activities. R2's page documented earning $20 per day for "cleaning apartment" on May 25, 2025 and July 13, 2025.

11.A review of documentation revealed a resident work log notebook. The notebook included a page for R5 that documented any money R5 earned for work they did and any money spent at outside activities. R5's page documented that on May 25, 2025 and June 7, 2025 R5 earned $20 per day for "cleaning apartment," and $10 on June 3, 2025 for "cleaning feet."

12.A review of documentation revealed a resident work log notebook. The notebook included a page for R10 that documented any money R10 earned for work they did and any money spent at outside activities. R10's page documented that on May 25, 2025 and June 7, 2025 R10 earned $20 per day for "cleaning apartment," and $10 on June 3, 2025 for "cleaning feet."

13.In an interview, R1 reported earning $7.00 per week doing chores at the facility. R1 stated residents who are "mentors" at the facility can make $10.00 per hour.

14.In an interview, R2 stated R2 earned $7.00 per week doing chores at the facility and "mentors" can make $10.00 per hour. R2 also reported R2 has earned a total of $1299.00 for work R2 had done since being admitted at the facility, including cleaning E1's off-site apartment and E1's home in [another town]. R2 reported R2 does not have access to the money but will get paid the lump sum when R2 is discharged.

15.In an interview, R3 stated residents make "[E1] money" by working for E1 at the facility or at E1's apartment, and stated R5 is E1's "number one worker."

16.In an interview, R5 reported going with E1 to E1's off-site personal apartment to clean and cook for E1 multiple times since R5's admission. R5 stated residents refer to this apartment as the "shop." R5 reported R5 was sometimes alone with E1. R5 stated to be E1's "main worker" and goes down to the "shop" daily to take care of E1's dogs, sometimes with one other resident, sometimes alone. R5 stated E1 lives at the "shop" during the week, then in [another town] on the weekend.

17.A review of the Industrial Commission of Arizona's website revealed a document titled, "The Fair Wages and Healthy Families Act," which stated, " Effective January 1, 2025, Arizona's Minimum Wage Is: $14.70 per hour..."

18.In the exit interview, the findings were reviewed with E1, E2, and E3. E1 stated the work the residents do was therapeutic because they are "learning how to work," and no additional comments or documentation were provided.

## Statement of Deficiency

| Rule | Evidence |
|---|---|
| R9-10-706.B.2.a. Personnel | Based on record review and interview, the |

B. An administrator shall ensure that:
2. A personnel member's skills and knowledge are verified and documented:
a. Before the personnel member provides physical health services or behavioral health services, and

administrator failed to ensure personnel member's skills and knowledge were verified and documented before the personnel member provided behavioral health services, for nine of eleven personnel members sampled. The deficient practice posed a risk if a personnel member was unable to meet a resident's needs.

Findings include:

1.A review of E1's (hired in 2017) personnel record revealed no documentation E1's skills and knowledge were verified before E1 provided physical health or behavioral health services.

2.A review of E2's (hired in 2017) personnel record revealed no documentation E2's skills and knowledge were verified before E2 provided physical health or behavioral health services.

3.A review of E3's (hired in 2018) personnel record revealed no documentation E3's skills and knowledge were verified before E3 provided physical health or behavioral health services.

4.A review of E4's (hired in 2019) personnel record revealed no documentation E4's skills and knowledge were verified before E4 provided physical health or behavioral health services.

5.A review of E5's (hired in 2023) personnel record revealed no documentation E5's skills and knowledge were verified before E5 provided physical health or behavioral health services.

6.A review of E7's (hired in 2025) personnel record revealed no documentation E7's skills and knowledge were verified before E7 provided physical health or behavioral health services.

7.A review of E9's (hired in 2025) personnel record revealed no documentation E9's skills and knowledge were verified before E9 provided physical health or behavioral health services.

8.A review of E10's (hired in 2024) personnel record revealed no documentation E10's skills and knowledge were verified before E10 provided physical health or behavioral health services.

9.A review of E11's (hired in 2025) personnel record revealed no documentation E11's skills and knowledge were verified before E11 provided physical health or behavioral health services.

10.In an interview, E3 asked for clarification of what was required for verifying a personnel member's skills and knowledge. E3 reported the facility did not have any documentation of verification of skills and knowledge for any personnel members and the facility based a personnel member's skills and knowledge on the personnel member's resume. E3 acknowledged no documentation of the verification of skills and knowledge existed for any personnel members.

11.In an exit interview, the findings were reviewed with E1, E2 and E3 and no additional comments were made or documentation were provided.

## Statement of Deficiency

### Rule

R9-10-706.G.3.h. Personnel

G. An administrator shall ensure that a personnel record is maintained for each

### Evidence

Based on record review and interview, the administrator failed to ensure a personnel record was maintained for each personnel

| | |
|---|---|
| personnel member, employee, volunteer, or student that includes:<br>3. Documentation of:<br>h. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-703(C)(1)(e); | member, employee, volunteer, or student that included documentation of cardiopulmonary resuscitation (CPR) training, for nine of eleven personnel records sampled. The deficient practice posed a risk if safety measures were not in place<br>to meet a resident's needs.<br>Findings include:<br>1.A review of E1's (hired in 2017) personnel record revealed no documentation of E1's CPR training.<br>2.A review of E2's (hired in 2017) personnel record revealed no documentation of E2's CPR training.<br>3.A review of E3's (hired in 2018) personnel record revealed an expired CPR card dated September 14, 2024. However, the card was for an online program and did not include a demonstration of skills.<br>4.A review of E4's (hired in 2019) personnel record revealed a CPR card dated July 23, 2025. However, the card was for an online program and did not include a demonstration of skills.<br>5.A review of E5's (hired in 2023) personnel record revealed a CPR card. However, the card was from an online program and did not include a demonstration of skills.<br>6.A review of E6's (hired in 2024) personnel record revealed a CPR card dated July 23, 2024. However, the card was for an online program and did not include a demonstration of skills.<br>7.A review of E7's (hired in 2025) personnel record revealed a CPR card dated June 13, 2025. However, the card was for an online |

program and did not include a demonstration of skills.

8.A review of E9's (hired in 2025) personnel record revealed a CPR card, dated July 23, 2025. However, the card was for an online program and did not include a demonstration of skills.

9.A review of E10's (hired in 2024) personnel record revealed a CPR card dated July 23, 2025. However, the card was for an online program and did not include a demonstration of skills.

10.In an interview, E3 and E10 acknowledged the trainings for E3 and E10 were completed online and did not include a demonstration. E3 reported to be unaware online CPR was not acceptable. E3 additionally acknowledged E4's and E10's trainings provided for review were completed online during the Department's on-site complaint investigation on July 23, 2025. E3 reported all personnel members were required to have CPR training.

11. In an exit interview, the findings were reviewed with E1, E2 and E3 and no additional comments were made or documentation were provided.

## Statement of Deficiency

### Rule

R9-10-706.J.1. Personnel

J. An administrator shall ensure that the following personnel members have first-aid

### Evidence

Based on documentation review, record review and interview, the administrator failed to ensure at least one personnel

and cardiopulmonary resuscitation training specific to the populations served by the behavioral health residential facility:
1. At least one personnel member who is present at the behavioral health residential facility during hours of operation of the behavioral health residential facility, and

member was present at the behavioral health residential facility during hours of operation of the behavioral health residential facility who had cardiopulmonary resuscitation (CPR) training specific to individuals 18 years of age or younger, for five of five personnel members present during the complaint investigation. The deficient practice posed a risk if safety measures were not in place to meet a resident's needs.

Findings include:

1.A review of facility documentation revealed a daily staffing schedule, titled "July 2025." The schedule included the daily staffing schedule for "Mon. 7/21 - Sun. 7/27." Listed for "Wed. 7/23" were E9 (8 am-4 pm), E10 (7 am-3 pm), E4 (7am -3 pm), E3 (7 am - 3 pm) and E5 (3 pm - 11 pm).

2.A review of E3's (hired in 2018) personnel record revealed a CPR card dated September 14, 2024. However, the card was for an online program and did not include a demonstration of skills.

3.A review of E4's (hired in 2019) personnel record revealed a CPR card dated July 23, 2025. However, the card was for an online program and did not include a demonstration of skills.

4.A review of E5's (hired in 2023) personnel record revealed a CPR card. However, the card was for an online program and did not include a demonstration of skills.

5.A review of E9's (hired in 2025) personnel record revealed a CPR card. However, the card was for an online program and did not include a demonstration of skills.

6.A review of E10's (hired in 2024) personnel record revealed a CPR card dated

July 23, 2025. However, the card was for an online program and did not include a demonstration of skills.

7.In an interview, E3 and E10 acknowledged the trainings for E3 and E10 were completed online and did not include a demonstration. E3 reported to be unaware online CPR was not acceptable. E10 acknowledged E3's and E10's CPR trainings were completed online during the complaint investigation. E3 additionally acknowledged at least one personnel member who had acceptable CPR training was not present at the behavioral health facility during the hours of operation during the inspection.

record revealed a CPR card. However, the card was for an online program and did not include a demonstration of skills.

6.A review of E10's (hired in 2024) personnel record revealed a CPR card dated July 23, 2025. However, the card was for an online program and did not include a demonstration of skills.

7.In an interview, E3 and E10 acknowledged the trainings for E3 and E10 were completed online and did not include a demonstration. E3 reported to be unaware online CPR was not acceptable. E10 acknowledged E3's and E10's CPR trainings were completed online during the complaint investigation. E3 additionally acknowledged at least one personnel member who had acceptable CPR training was not present at the behavioral health facility during the hours of operation during the inspection.

record revealed a CPR card. However, the card was for an online program and did not include a demonstration of skills.

6.A review of E10's (hired in 2024)

personnel record revealed a CPR card dated July 23, 2025. However, the card was for an online program and did not include a demonstration of skills.

7.In an interview, E3 and E10 acknowledged the trainings for E3 and E10 were completed online and did not include a demonstration. E3 reported to be unaware online CPR was not acceptable. E10 acknowledged E3's and E10's CPR trainings were completed online during the complaint investigation. E3 additionally acknowledged at least one personnel member who had acceptable CPR training was not present at the behavioral health facility during the hours of operation during the inspection.

record revealed a CPR card. However, the card was for an online program and did not include a demonstration of skills.

6.A review of E10's (hired in 2024)

personnel record revealed a CPR card dated July 23, 2025. However, the card was for an online program and did not include a demonstration of skills.

7.In an interview, E3 and E10 acknowledged the trainings for E3 and E10 were completed online and did not include a demonstration. E3 reported to be unaware online CPR was not acceptable. E10 acknowledged E3's and E10's CPR trainings were completed online during the complaint investigation. E3 additionally acknowledged at least one personnel member who had acceptable CPR training was not present at the behavioral health facility during the hours of operation during the inspection.

record revealed a CPR card. However, the card was for an online program and did not include a demonstration of skills.

6.A review of E10's (hired in 2024) personnel record revealed a CPR card dated July 23, 2025. However, the card was for an online program and did not include a demonstration of skills.

7.In an interview, E3 and E10 acknowledged the trainings for E3 and E10 were completed online and did not include a demonstration. E3 reported to be unaware online CPR was not acceptable. E10 acknowledged E3's and E10's CPR trainings were completed online during the complaint investigation. E3 additionally acknowledged at least one personnel member who had acceptable CPR training was not present at the behavioral health facility during the hours of operation during the inspection.

record revealed a CPR card. However, the card was for an online program and did not include a demonstration of skills.

6.A review of E10's (hired in 2024) personnel record revealed a CPR card dated July 23, 2025. However, the card was for an online program and did not include a demonstration of skills.

7.In an interview, E3 and E10 acknowledged the trainings for E3 and E10 were completed online and did not include a demonstration. E3 reported to be unaware online CPR was not acceptable. E10 acknowledged E3's and E10's CPR trainings were completed online during the complaint investigation. E3 additionally acknowledged at least one personnel member who had acceptable CPR training was not present at the behavioral health facility during the hours of operation during the inspection.

2.A review of R3's (admitted in 2025) medical record revealed a document titled, " Psychotherapy Treatment Plan," which included a start date in August of 2024 [sic].

The document was not signed or dated by the resident's representative.

3.A review of R10's (admitted in 2023) medical record revealed a document titled, " Psychotherapy Treatment Plan," which included a start date in October of 2023. The document was not signed or dated by the resident's representative.

4.In an interview, E2 reported E2 reviewed the treatment plans with each resident's representative by telephone during an individual counseling session with each resident. E2 reported obtaining verbal confirmation from the resident's representative, however, acknowledged the documents did not include a signature of the resident's representative and date signed.

5.In an exit interview, the findings were discussed with E1, E2 and E3 and no additional comments or documentation were provided.

## Statement of Deficiency

### Rule

R9-10-711.A.1. Resident Rights
A. An administrator shall ensure that:
1. The requirements in subsection (B) and the resident rights in subsection (E) are conspicuously posted on the premises;

### Evidence

Based on observation and interview, the administrator failed to ensure the requirements in subsection (B) and the resident rights in subsection (E) were conspicuously posted on the premises.

Findings include:

1. The Compliance Officers observed no conspicuously posted copy of the requirements in subsection (B) and the resident rights in subsection (E) posted on the premises.

2.
In an interview, E3 acknowledged there was no conspicuously posted requirements in

subsection (B) and the resident rights in subsection (E) posted on the premises.

3.
In an exit interview, E1 and E2 asked E3 if the re was a posting of the requirements in subsection (B) and the resident rights in subsection (E) posted on the premises. E3 acknowledged such requirements were not posted and no additional comments or documentation were provided.

## Statement of Deficiency

### Rule

R9-10-711.A.2. Resident Rights
A. An administrator shall ensure that:
2. At the time of admission, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (E); and

### Evidence

Based on documentation review and interview, the administrator failed to ensure, at the time of admission, a resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (E).

Findings include:

1.A review of the facilities policies and procedures revealed an undated policy titled, "Resident Rights." The document was not inclusive of the requirements in R9-10-711.B and the resident rights in R9-10-711.E.

2.A review of documentation revealed an undated document titled, "General House Rules," which included a section titled, "Youth Rights." The document was not inclusive of the requirements in R9-10-711.B and the resident rights in R9-10-711.E.

3.In an interview, R1, R2, R3, R4, and R5 reported to have been given a copy of the document titled, "General House Rules," which included the section titled, "Youth Rights," at the time of admission.

4.In an interview, E3 confirmed the document titled, "General House Rules," which included the section titled, "Youth Rights," was the documentation provided to the residents at the time of admission.

5.In an interview, E1, E2, and E3 acknowledged the resident rights provided to each resident at the time of admission to the facility were not inclusive of the requirements in R9-10-711.B and the resident rights in R9-10-711.E. and no additional comments or documentation were provided.

## Statement of Deficiency

### Rule

R9-10-711.B.1. Resident Rights
B. An administrator shall ensure that:
1. A resident is treated with dignity, respect, and consideration;

### Evidence

Based on observation and interview, the administrator failed to ensure a resident was treated with dignity, respect, and consideration. The deficient practice posed a potential for psychological distress, and posed a risk if the administrator was unable to ensure privacy in personal hygiene.

Findings include:

1.The Compliance Officers observed E4 screaming at residents in the bedroom hallway during the inspection, on numerous occasions.

2.The Compliance Officers observed six resident bedrooms. All six bedrooms contained surveillance cameras and three resident bedrooms did not contain doors.

3.In private resident interviews, multiple residents expressed frustration with a variety of facility personnel, including E4. Residents expressed being disrespected because the bedrooms contained video surveillance cameras and some bedrooms did not have doors to ensure privacy. Several residents expressed concerns of feeling shame and embarrassment during "intake showers," where, after admission they are asked to remove all of their clothing in the bathroom in front of two female staff so staff could note any scars on their bodies. Several residents expressed concern regarding the lack of privacy and the lack of privacy was disrespectful and lacked dignity.

4.In an interview, E3 acknowledged all of the bedrooms contained surveillance cameras. E3 also acknowledged three of the bedrooms did not have doors. E3 reported the cameras were there to provide security and was unsure why the doors had been removed.

5.In the exit interview, the findings were reviewed with E1, E2 and E3. E1 reported E4 had a loud speaking voice and E4 oftentimes yelled in normal conversations and no additional comments or documentation were provided.

## Statement of Deficiency

### Rule

R9-10-711.B.2.i. Resident Rights
B. An administrator shall ensure that:
2. A resident is not subjected to:
i. Restraint;

### Evidence

Based on documentation review and interview, the administrator failed to ensure a resident was not subjected to restraint. The deficient practice posed a potential for physical harm and psychological distress.

Findings include:

R9-10-701 states, "'Emergency safety response' means physically holding a resident to manage the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual."

1. A review of the facility's policies and procedures revealed an undated document titled, "Behavior Management," which stated,

"1. Neither Coach nor management of the program will allow the use of the following procedures:...group consequences, demeaning speech,...excessive physical force or unnecessary physical restraint on any of the Resident [sic]. All Coach will be trained in PCS (Positive Control Systems), which is a de-escalation technique. Coach may only use passive physical restraint as a temporary means of physical containment to protect the Resident, other persons, or property from harm when all other courses of action have not been successful in halting the undesirable or dangerous behavior...III...Coach must use wisdom and a good example to teach the Resident about the outcomes poor choices or good choices result in, and the consequences both good and bad that follow such choices..."

2. A review of the facility's policies and procedures revealed an undated document titled, " Restraint, Time In and Refocus," which stated, " ...Improved rules or time in practices are based on the belief that 'people have the right to be free from restraint or separation as a means of coercion, discipline, convenience, or retaliation' and that 'restraint and seclusion are not treatment, but rather represent an emergency response to a treatment failure that resulted in the individual's loss of control'...community based programs are subject to include: 1. Use of restraint and time out only during an emergency safety situation; 2, Use of the least restrictive safety intervention, discontinued as soon as the emergency safety situation has ended;...8. Require notification that restraint or seclusion has been utilized; 9. More specific reporting requirements for deaths and injuries...B... Recommendations: 1. A management philosophy that identifies restraint and time out as a last resort measure rather than a routine practice...C....4. Consider age, sex, and gender of Resident when setting time out and restraint policies...6. Continuously observe any Resident that is restrained...8. If a resident must be restrained in the prone position (face down) ensure that the airway is unobstructed at all times...Also ensure that expansion of the Resident's lungs is not restricted by excessive pressure on the Resident's back (special caution is required for children, adolescents, and obese

Residents)..."

3. A review of the facility's undated (copyright date 2021) emergency safety response training manual titled, " Positive Communication Systems: Crisis Intervention Program," which states, "...B. Use of Force Considerations; 1. Use of force in a therapeutic environment is only applied when: a. Violence is occurring; b. Resident(s) and/or staff are in immediate peril (imminent threat/danger); c. The safety of the resident is in jeopardy. 2. Use of force is not to be used as a punishment and residents are to be protected as much as possible from injury. 3. The staff members should use methods when physically intervening with residents to ensure: a. Safety for residents and staff alike; b. Division and Department policies and procedures are met; c. Resident's legal rights are not violated..."

4. A review of R2's medical record revealed a document titled, "Incident Report Form," dated October 28, 2024, which stated, "...Primary Staff Involved: [E4]...[R2] was causing a situation. [R2] got up and ran towards the kitchen, stating that [R2] was going to beat someone up...Staff made it to [R2] as [R2] was put into a PCS hold...[R2] continued to be aggressive and was put into a PCS hold on the ground..."

5. A review of R2's medical record revealed a document titled, "Program Incident Report Form," dated August 25, 2024, which stated, " [R2] was called outside...when [R2] came in staff was passing meds. [R2] failed to ask to cross, walked passed the med cart and straight to [R2's] room without doing safety checks...[R2] was told [R2] was getting a class 3 for safety violation. [R2] became angry...walking down the hall and hitting the walls screaming...began body slamming the door...came back to the med cart and began to argue in the middle of med pass. [E7] told [R2] [E7] was trying to pass meds and [R2] needed to step back and stop and wait till [sic] [E7] was finished with meds, [R2] continued to argue [E7] asked [R2] several times and told here [sic] if [R2] didn't we would assist [R2]. [R2] laughed and said we

could not, we proceeded to assist [R2] out of the med pass area [R2] was punching and biting, we assisted [R2] to the floor...7. Was the resident and staff checked for any injuries? Yes, resident may have a bruise on [R2's] right forehead, staff has bruises to both wrists and broken skin to the right wrist..."

6. A review of R4's medical record revealed a document titled, "Incident Report Form," dated May 25, 2025, which stated, "..There was a situation going on that had staff a bit pre-occupied and peer...went to talk to [R4] and found [R4] with a standing fan cord wrapped around [R4's] neck. [Peer] yelled for staff...[R4's] peer...came out of the room carrying the standing fan...[R2] was sitting on the bed and [E7] moved into escort [R4]...[R4] was put into a PCS restraint to escort [R4] down the hall..."

7. A review of R4's medical record revealed a document title, "Program Incident Report Form," dated May 23, 2025, which stated, "...[R4] left the classroom without permission...[R4] said [R4] was not leaving [R4's] room, as [E7] watched [R4] wrapped a hair tie around [R4's] throat, staff went to [R4's] room [R4] was put into a PCS restraint and put on the floor but [R4] proceeded to bang [R4's] head on the floor and [E7] had to hold [R4] by [R4's] hair as [E7] was sitting on [R4's] legs to prevent us from getting kicked and 2nd staff was holding [R4's] right arm..." The document also stated, "1. What was done to de-escalate the situation and prevent the contact/problem? Restraint was necessary; 2. What was the client's attitude and demeanor prior to the incident? Moapinng [sic] and complaining..."

8. A review of R4's medical record revealed a document title, "Program Incident Report Form," dated May 23, 2025, which stated, "...[E11] walked into the room and [R4] was trying to take the hair tie back from [E7]. [R4] let go and tried to cut [R4's] self with a small wire. [E7] and [E11] started PCS restraint placing [R4] on the ground...." The document also stated, " 1. What was done to de-escalate the situation and prevent to

contact/problem? Restraint was needed due to safety; What was the client's attitude and demeanor just prior to the incident? Tired, sick, quiet, overthinking..."

9. In an interview, R2 stated if residents are trying to fight, staff will "put [the residents] on the floor, or put their hands behind their backs and twist their wrists." R2 reported R2 was restrained 3 months ago. During this restraint R2 reported staff twisted R2's wrist and put R2 down to the ground, stating "it hurt." R2 also stated staff will use their hands or knee to hold the residents down on the floor "like police grabbing you."

10. In an interview, R3 stated R3 witnessed another resident get restrained by two adult male personnel members because the resident refused to take an "intake shower," reporting the two males held the resident down on the ground using the weight of their bodies.

11. In an interview, R4 stated R4 had been restrained on numerous occasions, and that each time, R4 felt "scared." When asked what the restraints looked like, R4 stated "staff holds [residents] wrists' back and puts [residents] on the floor." R4 reported staff use their knees to hold residents down and prevent them from moving around. Regarding the incident report from May 23, 2025, R4 reported E7 bent R4's wrist back and kneeled on R4 on the floor.

12. In an interview, R5 reported R5 had seen other residents be restrained. R5 said R5 had seen residents have their wrists bent backwards by E1, E3 and E4. R5 reported E1, E3 and E4 came to R5's family member's house to pick R5 up to bring R5 to the facility and R5 resisted. R5 reported E3 bent R5's wrist back and restrained R5 to get R5 into the van to bring R5 to the facility.

13. In an interview, E3 confirmed E3 was the PCS instructor who trained all the personnel members in PCS restraints. E3 reported not to be aware restraints could not be used on

the residents.

14. In the exit interview, the findings were reviewed with E1, E2, and E3 and no additional comments or documentation were provided.

## Statement of Deficiency

### Rule

R9-10-711.B.3.b. Resident Rights
B. An administrator shall ensure that:
3. Except as provided in subsection (C) or (D), and unless restricted by the resident's representative, a resident is allowed to:
b. Have privacy in correspondence, communication, visitation, financial affairs, and personal hygiene; and

### Evidence

Based on documentation review, record review, and interview, the administrator failed to ensure a resident was allowed to have privacy in correspondence, communication, visitation, financial affairs and personal hygiene. The deficient practice posed a risk as the repeated violation shows a pattern of noncompliance to ensure the health and safety of residents.

Findings include:

1.A review of documentation revealed a document titled, "General House Rules," which stated, "...12...If you want to mail a letter, you must give the letter to your therapist for approval. If approved, your letter will be sent. Any violation of these rules will result in loss of privileges. Mail received will be reviewed by your therapist or Program Director before you receive it..."

2.A review of the facility's polices and procedures revealed a document titled, "Resident Telephone Privileges," which stated, " Staff will supervise all incoming and outgoing phone calls by remaining close enough to determine if an inappropriate conversation is occurring..."

3.In an interview, R1 reported R1 was allowed talk to R1's family every other week with staff present, and weekly in individual therapy sessions with E2 present. R1 reported R1 was only allowed to speak with family on speaker phone so that the conversation was monitored. R1 also reported staff reads the residents' mail before giving it to them to make sure it is appropriate and does not include any contraband. R1 reported staff also reads residents outgoing mail to make sure there is nothing negative or manipulative written in it or it will not be mailed.

4.In an interview, R2 reported not being able to call R2's family in private as the call has to be on speaker phone. R2 also reported staff opens R2's mail to read what R2's family says to R2 before R2 can read it, and reported this is because staff is looking for contraband.

5.In an interview, R3 reported staff was always in the room when R3 calls family and the call has to be on speaker. R3 reported E3 told R3 if R3 says anything negative on the phone E3 will hang up the phone. R3 stated E10 has let R3 be alone in the "quiet room" to talk to family on speaker while E10 waits outside. R3 stated staff reads residents' mail and opens their packages before the residents get it, and if the mail is "not good" staff will not give it to the residents.

6.A review of R1's (admitted in 2023) medical record revealed a document titled, "Psychotherapy Treatment Plan," which included a start date in January of 2024. The document did not include the requirements in R9-10-711.D.

7.A review of R2's (admitted in 2023) medical record revealed a document titled, "Psychotherapy Treatment Plan," which included a start date in June of 2023. The document did not include the requirements in R9-10-711.D.

8.A review of R3's (admitted in 2025) medical record revealed a document titled, "Psychotherapy Treatment Plan," which included a start date in August of 2024 [sic]. The document did not include the requirements in R9-10-711.D.

9.In the exit interview, E1 and E2 reported the residents' parents required no privacy with calls or communication in order to protect the residents from other people they did not want them communicating with, and no additional comments or documentation were provided.

This is a repeat violation from the complaint investigation conducted on May 25, 2022.

## Statement of Deficiency

### Rule

R9-10-716.A.2.b. Behavioral Health Services
A. An administrator shall ensure that:
2. If a behavioral health residential facility is licensed to provide behavioral health services to individuals whose behavioral health issue limits the individuals' ability to function independently, a resident admitted to the behavioral health residential facility with limited ability to function independently receives:
b. Continuous protective oversight;

### Evidence

Based on documentation review, observation and interview, the administrator failed to ensure a behavioral health residential facility licensed to provide behavioral health services to individuals whose behavioral health issue limits the individuals' ability to function independently, a resident admitted to the behavioral health residential facility with limited ability to function independently received continuous protective oversight. The deficient practice posed a risk as residents who required continuous protective oversight were left unsupervised.

Findings include:

1.A review of Department documentation revealed BH5273 was licensed to provide behavioral health services to residents under the age of 18.

2.The Compliance Officers observed, upon arrival to BH5273, R5 in the front of the facility. R5 was alone, unsupervised and appeared to be performing maintenance on the facility grounds.

3.In an interview, R5 confirmed R5 was a resident. R5 stated R5 was "dependent" but had recently dropped down from being a mentor. R5 stated R5 was allowed to be unsupervised around the facility to perform maintenance, help out at "the shop" and tend to the facility grounds.

4.In an exit interview, the findings were reviewed with E1, E2 and E3 and no additional comments were made or documentation were provided.

## Statement of Deficiency

### Rule

R9-10-716.A.7.a. Behavioral Health Services
A. An administrator shall ensure that:
7. A resident does not:
a. Use or have access to any materials, furnishings, or equipment or participate in any activity or treatment that may present a threat to the resident's health or safety based on the resident's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, or personal history; or

### Evidence

Based on documentation review, record review, and interview, the administrator failed to ensure a resident did not participate in any activity or treatment that may have presented a threat to the resident's health or safety based on the resident's documented treatment needs, or personal history. The deficient practice posed a risk as R5's and R10's personal histories were not considered prior to participating in an activity that could cause harm.

Findings include:

1.A review of the facilities policies and procedures revealed an undated document titled, "Sexual Misconduct," which stated, "...Residents are assessed for risk of sexual acting out behavior or of being sexually victimized. The facility takes protective measures for residents who may be vulnerable to sexual victimization or sexually acting out...B. Early Intervention; 1...The assessment process will consider the individual circumstances of the resident...including...being sexually abused...sexually hypersexual behaviors,...promiscuity, age, physical size...."

2.A review of the facility's policies and procedures revealed an undated document titled, "Therapeutic Services," which stated, "1. Each Resident will receive Therapeutic Services consistent with the Resident's needs...VI. The treatment plan will contain the findings of the intake evaluation and assessment, and measurable long and short-term goals and objectives. The treatment plan details that the goals or objectives are clearly derived from assessment information..."

3.A review of the facility's policies and procedures revealed an undated document titled, "Resident & Coach Relation," which stated, "...All employees are expected to maintain a staff/resident relationship that contributes to the Program's therapeutic environment...A. In all dealings with residents, employees must adhere to professional relationships that maintain appropriate boundaries. B. Employees will not become emotionally or physically involved with any resident in a manner that transcends the bounds of a therapeutic relationship...C. Employees must not become involved in relationships with residents that are used for their own personal gain...G. Staff will not give a resident any personal information, phone numbers, addresses or e-mail addresses of themselves or another employee..."

4.A review of R5's medical record revealed an undated document titled, "Biopsychosocial Intake," completed in September of 2024 and signed and dated by E2 on July 23, 2025. The document stated, "...Psychosocial History: ...Sexual History: [R5's] mother indicated [R5] has been sexually promiscuous and has had a relationship with an adult young [person] a few years older...[R5] has engaged secretly in this relationship and in hooking up with [people] for the past couple of years without permission and sneaking out of the house..."

5.A review of R10's medical record revealed an undated document titled, "Biopsychosocial Intake," completed in September of 2023.. The document stated, "...Psychosocial History:...Parents describe client as being sexually seductive, demanding in [R10's] behavior, and manipulative..."

6.A review of documentation revealed a resident work log notebook, which had a page for each resident that documented any money they earned for work they did and any money spent at outside activities. R5's and R10's pages documented that on May 25, 2025 and June 7, 2025, R5 and R10 earned $20 per day each for "cleaning apartment," and $10 each on June 3, 2025 for "cleaning feet."

7.In an interview, R3 stated R5 is E1's "number one worker," and that R3 has heard rumors from multiple people regarding R5 and E1 being in a sexual relationship.

8.In an interview, R5 reported going with E1 to E1's off-site personal apartment to clean and cook for E1 multiple times since R5's admission. R5 stated the residents refer to this apartment as the "shop." R5 reported R5 is sometimes alone with E1. R5 stated to be E1's "main worker" and goes down to the "shop" daily to take care of E1's dogs, sometimes with one other resident, sometimes alone. R5 stated E1 lives at the "shop" during the week, then in [another town] on the weekend.

9.In an interview, R5 reported other residents have made comments to R5 about R5 and E1 being in a sexual relationship. R5 reported feeling hurt by this as R5 feels R5 had a close relationship with E1 because R5 lost R5's father at a young age.

10.In the exit interview, the findings were reviewed with E1, E2, and E3 and no additional comments or documentation were provided.

## Statement of Deficiency

### Rule

R9-10-721.A.1.c. Environmental Standards
A. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:
1. The premises and equipment are:

### Evidence

Based on observation, record review and interview, this administrator failed to ensure the premises were free from a condition or situation that may cause a resident or other individual to suffer physical injury.

c. Free from a condition or situation that may cause a resident or other individual to suffer physical injury;

Findings include:

1.The Compliance Officers observed a hallway resident bathroom. The bathroom contained two wooden shelves. Each shelf contained two hooks. None of the hooks gave way when the Compliance Officer applied downward pressure.

2.A review of R4's (admitted in 2024) medical record contained documentation of R4's numerous suicide attempts, including an incident report, dated in May 2025. The document stated "...found [R4] with a standing fan cord wrapped around [R4's] neck." An additional incident report, dated in May 2025 stated "...as I watched [R4] wrapped a hair tie around [R4's] throat...."

3.A review of R7's (admitted in 2024 and discharged in 2025) medical record revealed documentation R7 had previous suicidal attempts both at home and other treatment facilities.

4.A review of R10's (admitted in 2023) medical record contained documentation of R10's history of suicide attempts, including attempted suicide by hanging and cutting.

5.In an interview, E4 reported the hooks would withstand 75 pounds of pressure. E4 was unable to provide documentation or evidence to support the 75 pounds of pressure statement.

6.In an exit interview, the findings were reviewed with E1, E2 and E3 and no additional comments were made or documentation was provided.

## Statement of Deficiency

**Rule**

**Evidence**

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|---|---|
| R9-10-721.A.7. Environmental Standards<br>A. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:<br>7. Heating and cooling systems maintain the behavioral health residential facility at a temperature between 70° F and 84° F; | Based on observation and interview, the administrator failed to ensure heating and cooling systems maintained the behavioral health residential facility at a temperature between 70° F and 84° F.<br>Findings include:<br>1.The Compliance Officers observed the temperature in bedroom number one to be measured at 92.3° F, using a Department-issued thermometer.<br>2.The Compliance Officers observed the temperature in bedroom number two to be measured at 91.2° F, using a Department-issued thermometer.<br>3.The Compliance Officers observed the temperature in bedroom number three to be measured at 87.7° F, using a Department-issued thermometer.<br>4.The Compliance Officers observed the temperature in bedroom number four to be measured at 87.4° F, using a Department-issued thermometer.<br>5.The Compliance Officers observed the temperature in bedroom number five to be measured at 89.3° F, using a Department-issued thermometer.<br>6.In an interview, E3 acknowledged the facility's bedrooms were warmer than 84°F. E3 reported the residents were not allowed in the bedrooms during the day. E3 reported the hallways and other parts of the facility were cooled by the swamp cooler in the hallway.<br>7.In an exit interview, the findings were discussed with E1, E2 and E3 and no additional comments or documentation were provided. |

## Statement of Deficiency

| Rule | Evidence |
|---|---|
| R9-10-722.B.8.k. Physical Plant Standards<br>B. An administrator shall ensure that:<br>8. A resident bedroom complies with the following:<br>k. Has a clothing rod or hook in the bedroom designed to minimize the opportunity for a resident to cause self-injury. | Based on observation, record review and interview, the administrator failed to ensure a resident bedroom complied with the following: had a clothing rod or hook in the bedroom designed to minimize the opportunity for a resident to cause self-injury. The deficient practice posed a risk of physical injury to a resident who had a history of suicide attempts.<br>Findings include:<br>1.The Compliance Officers observed six resident bedrooms. The bedrooms contained the following: Bedroom number one contained 2 hooks, Bedroom number two contained 2 hooks, Bedroom number three contained 2 hooks, Bedroom number four contained 3 hooks, Bedroom number five contained 3 hooks and Bedroom number six contained 3 hooks. None of the hooks gave way when the Compliance Officer applied downward pressure.<br>2.A review of R4's (admitted in 2024) medical record contained documentation of R4's numerous suicide attempts, including an incident report, dated in May 2025. The document stated "...found [R4] with a standing fan cord wrapped around [R4's] neck." An additional incident report, dated in May 2025 stated "...as I watched [R4] wrapped a hair tie around [R4's] throat...."<br>3.A review of R7's (admitted in 2024 and discharged in 2025) medical record revealed documentation R7 had suicidal attempts both at home and other treatment facilities.<br>4.A review of R10's (admitted in 2023) medical record contained documentation of R10's history of suicide attempts, including attempted suicide by hanging and cutting. |

5.In an interview, E4 reported the hooks would only withstand 75 pounds of pressure. E4 was unable to provide documentation or evidence to support the 75 pounds of pressure statement.

6.In an exit interview, the findings were reviewed with E1, E2 and E3 and no additional comments or documentation were provided.