



ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

MINGUS MOUNTAIN ESTATE RESIDENTIAL CENTER, INC

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

MINGUS MOUNTAIN ESTATE RESIDENTIAL CENTER, INC

Address

100 Dewey Road, Dewey, AZ 86327

Accreditation

The Joint Commission (TJC)

Phone

6023352000

Maximum Licensed Capacity

9

Behavioral Health Professional

Michelle Kyliavas

Chief Administrative Officer

SHAUN MOHON

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.

Facility Status

Active ⓘ

License Status

Active ⓘ

License

BH1122

License Effective

5/1/2025

License Expires

4/30/2026

Owner / Licensee

MINGUS MOUNTAIN ESTATE RESIDENTIAL CENTER, INC.

Additonal Information

BH Residential Facility - Child

3/19/2024 Inspection

Inspection #

INSP-0077609

Inspection Date(s)

3/19/2024

Status

Complete

Inspection Type

Complaint

Location Type

Worksheet Type

Behavioral Health Residential Facility

Certificate Number

BH1122

Initial Comments

An on-site investigation of complaint was conducted on March 19, 2024 and the following deficiencies were cited :

Statement of Deficiency

Rule

G. An administrator shall provide written notification to the Department of a resident's: 2. Self-injury, within two working days after the resident inflicts a self-injury or has an accident that requires immediate intervention by an emergency medical services provider.

Evidence

Based on record review, documentation review, and interview, the administrator failed to provide written notification to the Department of a resident's self-injury, within two working days after a resident inflicted self-injury or had an accident that required immediate intervention by an emergency medical services provider. This deficient practice posed a health and safety risk to residents. Findings include: 1. A review of R1's medical record revealed an incident report dated March 13, 2024. The report stated, "...Clients then got in the van with [R1] driving and began driving down the driveway. The van got going to (sic) fast and clients rolled the van down the driveway taking out the fence and the neighbors fence. Clients then got out the (sic) van and began Awoling. [R1] ran to Prescott country club where [R1] eventually asked for help because [R1] was injured from the accident. A man helped them and had them call mingus and then called the police and stayed with them until police arrive as well as EMT's to the scene ...Clients were separated by police and taken to the hospital for further evaluation." 2. A review of R2's medical record revealed an incident report dated March 13, 2024. The report stated, "...Clients then got in the van with [R1] driving and began driving down the driveway. The van got going to (sic) fast and clients rolled the van down the driveway taking out the fence and the neighbors fence. Clients then got out the (sic) van and began Awoling. [R2] ran to Prescott country club where [R2] asked a man for assistance as [R2] and [R1] were injured ...Clients went to hospital to be assessed and then were detained." 3. A review of facility documentation revealed an "Incident, Accident or Death Report" was created on March 14, 2024, and submitted to "T/RHBA" on March 14, 2024 at 12:59:57 AM. The document identified R1 as the "Member" and detailed the aforementioned incident. However, no documentation which showed the report was submitted to the Department within two working days of the incident was available for review. 4. A review of Department documentation revealed written notification of the aforementioned incident was not received by the Department. 5. In an interview, E1 acknowledged the administrator failed to provide written notification to the Department, within two working days after a resident inflicted self-injury or had an accident that required immediate intervention by an emergency

medical services provider. E1 reported E1 would update the facility's incident reporting policies and procedures to ensure future compliance.

Plan of Correction

Name, title and/or Position of the Person Responsible

Temporary Solution

Permanent Solution

Date temporary correction was implemented

Monitoring

Date permanent correction will be complete
2024-03-22

Statement of Deficiency

Rule

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, record review, and interview, the administrator failed to ensure, if a behavioral health residential facility was licensed to provide behavioral health services to individuals whose behavioral health issue limits the individuals' ability to function independently, a resident admitted to the behavioral health residential facility with limited ability to function independently received continuous protective oversight. The deficient practice posed a health and safety risk to residents who required continuous protective oversight due to being minors under the age of 18. Findings include: 1. A review of Department documentation revealed the facility was licensed to provide behavioral health services to individuals whose behavioral health issue limits the individuals' ability to function independently. 2. A review of facility policies and procedures revealed a policy titled, "Program Description" which stated, "MINGUS MOUNTAIN YTC serves females ages 12 to 17 with emotional disorders, behavioral disorders, victims of physical, sexual, or emotional abuse, or substance abuse problems." 3. A review of facility policies and procedures revealed a policy titled, "Client Supervision, Policy Number GLV301" which stated, "All Mingus Mountain Youth Treatment

Center employees will maintain appropriate supervision in the following critical areas ...D - Distance: All employees will have appropriate distance between themselves and the student(s) they are in direct supervision of. This is to ensure that the employee has the ability to appropriately supervise conversations and intervene for safety and well-being of our clients. E - Eyesight: Appropriate supervision involves on duty staff members performing consistent and regular unobstructed visual inspections with a clear line of sight on all clients in their care. The only exception would be when we are to provide privacy to a student such as being in the bathroom or shower. When clients are in their bedrooms for more than 15 minutes, staff members will refer to the overnight room checks standard operating procedure. A - Awareness: All employees are to have an active awareness of the clients(s) they are in direct supervision of ..." 4. A review of facility documentation revealed a document titled, "Farrington House CIR." The document detailed a "Critical Incident Review of 3/13/24 incident where three clients of Farrington House group home stole and rolled the company van, went AWOL, and were subsequently arrested." The investigation contained a section titled "Audit Findings" which stated, "Estimated Risk Level: Severe; Summary of Contributing Factors: Supervision Protocols, Staff Placement ...Supervision Protocols: The staff member on shift, based on video footage obtained, opened the locker for the clients per their request to obtain scissors to open a food package. While the staff member remained next to the locker, [R2] was not actively supervising the clients accessing the locker, as [R2] was distracted by another client. This was a violation of policy ...Staff Placement: The staff member on shift was not placed in an area where [R2] could supervise client movement throughout the home. The three clients involved in the incident were able to freely move between their bedrooms and the living room without staff intervening or resetting movement and their own position to supervise the group. This was a violation of policy. Client Supervision, GLV301 ...Staff member on shift will receive a written coaching for the two aforementioned policy violations." 5. A review of R1's medical record revealed an incident report dated March 13, 2024. The report stated, "[R1] woke up and began going to peers asking them to AWOL

with her. [R1] asked clients [R2] and [R4] to join and began discussing it in [R1's] bedroom ...Client and peers were then addressed for having an unspotted conversation and talking in a room they weren't supposed to be in ...Clients began packing things and taking them to room 1 where they tore off the sensor for the window to the room. Clients involved then asked staff to open up the staff cabinet to grab something out of it. [R1] and a peer also caused a distraction at this time so staff would turn away from the cabinet and one of them could steal the van keys. Clients then tried to play hide and seek to create a distraction. Clients had high movement and used this as a distraction to open the window in room one where they had taken the sensor off the wall and jumped out as well as ran out the back door. Clients then got in the van with [R1] driving and began driving down the driveway ..." 6. A review of R2's and R3's medical records revealed separate incident reports dated March 13. Both incident reports indicated staff was distracted while residents planned to leave the facility, stole keys to the facility's van, and "opened the window in room one where they had taken the sensor off the wall and jumped out as well as ran out the back door." R1's, R2's, and R3's incident reports also contained a "Debriefing" section which stated, "Identified intervention opportunities that may have prevented the incident: Staff could have better supervision and slowed movement." 7. In an interview, E1 reported the facility had investigated the incident and addressed the causes identified in the investigation. E1 acknowledged the residents were minors under the age of 18 who required continuous protective oversight. E1 further acknowledged the administrator failed to ensure R1, R2, and R3 received continuous protective oversight from facility staff during the March 13, 2024 incident.

Plan of Correction

Name, title and/or Position of the Person Responsible	Temporary Solution
Date temporary correction was implemented	Permanent Solution
Date permanent correction will be complete 2024-04-04	Monitoring