Preliminary Investigation Report
Disability Rights New Mexico
Strategic Behavioral Health dba Peak Behavioral Health
December 8, 2015

Summary of Contents

I. Introduction

DRNM, an independent non-profit organization, has been the state's designated protection and advocacy (P&A) agency since 1979. Congress found that people with mental illness are "vulnerable to abuse and serious injury" and created the P&A agencies to protect and promote the rights of people with disabilities, authorizing them to "investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred." 42 USC §10801 (b). DRNM is authorized to conduct investigations in any facility in New Mexico providing care or treatment 42 USC § 10802, 42 USC § 10805 (a)(1)(A).

In January 2014, Disability Rights New Mexico (DRNM) began receiving consumer complaints regarding Strategic Behavioral Health dba Peak Behavioral Health in Santa Teresa, NM. "The Peak," as it is commonly called, is a 119-bed facility located in a rural area in southern New Mexico near El Paso, TX. The complaints came directly from residents in the adolescent Residential Treatment Center (RTC) and covered a variety of concerns regarding the use of restraints: unnecessary restraints, improper restraints that resulted in injuries, and the use of chemical restraint. Additionally, DRNM received grievances from residents who were forced to wear paper scrubs and were banned from going outside or to school.

In response to these concerns, DRNM staff began visits to monitor the Peak's adolescent RTC in February 2014. Through monitoring visits, DRNM found probable cause to believe that individual residents at the Peak may have been subject to abuse or neglect. Residents reported painful restraints that resulted in bruises, sprained or hurt arms, as well as incidents of being thrown against walls and having their faces smashed into door frames and foot boards of beds. Residents also reported verbal abuse by staff, including name-calling and threats of physical

harm, as well as a lack of sufficient therapies, not being allowed to use the restroom during the four-hour school day, and not being allowed to call their attorneys, Juvenile Probation Officers (JPOs), or DRNM. Consequently, on February 28, 2014, DRNM sent a probable cause letter to the Peak administration and launched an investigation of the Peak's RTC units.

II. Summary of Findings/Findings of Fact

A comprehensive review of incident reports from September 2014-September 2015 reveals data supporting the assertion that Strategic Behavioral Health provided an unsafe environment to residents on the adolescent RTC units at the Peak. DRNM concludes these residents, ages 12-18, were exposed to a pattern and practice of neglect as defined by 7.20.11.7 NMAC CL. (2-4).

During the 13-month period of focused document review, DRNM staff found that:

1. There were 80 incidents involving resident-on-resident violence or aggression.
2. Numerous injuries resulted from the 80 incidents of resident-on-resident fighting. Types of injuries included a fractured nose, loss of teeth, bleeding and swollen open lips, ecchymosis, a cut requiring stitches, and eye, hand, and ankle injuries requiring X-rays.
3. Peak staff documented six trips to the ER or Urgent Care clinic for injuries incurred from fighting that required medical care beyond the Peak's scope of practice.
4. Law enforcement was called 21 times to the Peak's adolescent RTC during the 13-month period.
5. Four residents were charged with Class III Battery for attacking other residents.
6. There were 53 incidents involving resident suicide attempts or self-harm.
7. There were 23 incidents of resident elopement from the facility.
8. Five residents made allegations of a sexual nature against other residents.

9. One resident was injured while being restrained in a “chokehold” by a Mental Health Technician (MHT).

III. Structure of Investigation/Methodology

In February 2014, DRNM staff began monitoring activities to determine the scope of the investigation. These activities included:

1. frequent visits to the Peak to meet with residents on the adolescent RTC units regarding their concerns, and
2. reviewing incident reports generated by Peak staff, including restraint reports and critical incident reports.

The site visits to the Peak’s RTC units were conducted by a DRNM Advocate. During the visits, DRNM met with groups of residents on each unit and privately if the residents requested. In addition to educating residents about their rights, she documented resident concerns and presented these issues to Peak administration in person, by phone, and in writing.

Over the course of the investigation, DRNM received monthly copies of incident reports from the Peak. These included both restraint reports and incident reports of a “critical” nature as determined by Peak staff. The incident reports were reviewed by a DRNM Advocate and Paralegal, who followed up with Ms. Sylvia Huerta-Lopez, Risk Assessment Manager at the Peak, on events that were of a significant nature.

In August 2015, DRNM staff observed a significant increase in activity in two particular areas. These areas included:

1) incidents of resident-on-resident violence, and

2) the use of psychotropic medication injections following incidents of physical restraint.

The charts below demonstrate the increase in these two activity areas:

Incidents of Resident-on-Resident Violence or Aggression per Peak incident reports, Sept. 2014 - Sept. 2015

Month	Frequency
Sept 2014	2
Oct 2014	1
Nov 2014	7
Dec 2014	9
Jan 2014	6
Feb 2014	4
Mar 2014	4
Apr 2015	3
May 2015	2
June 2015	7
July 2015	16
Aug 2015	15
Sept 2015	4
Year Total	80

Use of injections following physical restraints,
as recorded by Peak staff on incident reports Sept. 2014 - Sept. 2015

Month	Number of injections following physical restraints
Sep 2014	6
Oct 2014	5
Nov 2014	17
Dec 2014	15
Jan 2015	3
Feb 2015	2
Mar 2015	6
Apr 2015	3
May 2015	7
Jun 2015	2
Jul 2015	5
Aug 2015	19
Sep 2015	15
Year Total:	105

In response to these trends, DRNM staff performed a comprehensive review of the data collected from the Peak between September 2014 and September 2015.

Document Review Protocol

During the 13-month period of focused review, DRNM received 316 incident reports from the Peak. Of the 316 reports received, 245 were labeled as restraint incident reports while the remaining 71 were classified by the Peak as "critical" incidents. With resident safety concerns in mind, DRNM staff separated both categories of incidents into six further classifications:

1. Resident-on-resident violence or aggression
2. *Attempted* resident-on-resident violence or aggression
3. Resident-on-staff violence or aggression
4. Resident self-harm, including suicide attempts
5. Resident elopement
6. Other significant events involving resident safety.

A summarizing description of each of the 316 incident reports was entered by a DRNM Advocate into a database. This database provided the framework for DRNM staff to analyze and evaluate the incident reports collected from September 2014-September 2015 by frequency and type. Please see Appendix item 1 for a comprehensive chart detailing the Peak Incident Reports submitted to DRNM between September 2014 and September 2015.

In addition to reviewing the above incident reports, DRNM staff performed an in-depth analysis regarding the use of restraints during the period of focused review. A focused discussion on restraint use and its impact on resident safety will follow below.

IV. Statutory/Regulatory Authority and Review of Documentary Evidence

The law and regulations applicable to this investigation are as follows:

Code of Federal Regulations, Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21, 42 CFR §§ 483.350 through 483. 376.

New Mexico Children's Mental Health and Developmental Disabilities Act, NMSA 1978, §§ 32A-6A- 1 et seq.

New Mexico Administrative Code, Certifications for Child and Adolescent Mental Health Services, 7.20.11 et seq.

A review of the 316 incident reports submitted by the Peak to DRNM revealed that Strategic Behavioral Health provided an unsafe environment for the residents at the RTC between September 2014 - September 2015. This unsafe environment was the result of a pattern and practice of neglect as defined by 7.20.11.7 CL. (2-4), NMAC.:

"NEGLECT by individuals or an agency means:

2) failure to take any reasonable precaution that is necessary to prevent damage to the health or safety of a client; or

3) failure to carry out a duty to supervise properly or control the provision of any treatment, care, good service or medication reasonably necessary to maintain the health or safety or a client; or

4) failure to take any reasonable precaution that would prevent the physical abuse, sexual abuse, or sexual exploitation of a client, as defined in the Children's Code at 1978 NMSA 32A-4-2, or the lack of which causes the client to become an abused child or neglected child as defined the Children's Code at NMSA 1978 32A-4-2."

In addition, Strategic Behavioral Health failed to use emergency safety interventions "in a manner that [was] safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical and psychiatric

condition; and personal history (including any history of physical or sexual abuse)." 42 CFR §483.356(b).

DRNM found evidence that Strategic Behavioral Health:

a. was aware of the damage to the health and safety of its clients, as evidenced by the completion of the incident reports documenting harm or attempted harm to residents;

b. failed to supervise properly or control the provision of treatment as evidenced by the Peak staff's failure to maintain an environment free from continuous, violent incidents; and

c. failed to take the reasonable precautions that would have prevented the physical abuse and alleged sexual abuse of its clients by permitting the conditions that led to:

i. 80 incidents of resident-on-resident violence

ii.53 incidents of self-harm or suicide attempts

iii.23 elopements

iv.22 other significant incidents, including 5 allegations of resident-on-resident sexual assault, during the 13-month period of focused review.

Resident-on-Resident Violence and Aggression at the Peak

From September 2014-September 2015, Peak staff recorded 80 separate incidents of resident-on-resident violence or aggression. Residents sustained numerous injuries during these episodes, with six trips to the ER or Urgent Care clinic recorded. Documentation of injuries due to resident-on-resident fighting included: a fractured nose, loss of teeth, a bleeding and swollen open lip, ecchymosis, a cut requiring stitches, and eye, hand, and ankle injuries.

Notable incidents involving resident-on-resident violence or aggression included:

- 11/27/14 – A resident was attacked by a peer with a pencil causing a 1-inch laceration to the victim's head.

- 12/7/14 - A resident was attacked by a group of peers and immediately began to self-harm. Witnesses to this incident later reported to DRNM that the staff present failed to initially respond to this event, and that it was residents, not staff, who broke up the fight.
- 1/6/15- A resident was hit by a peer and taken to the ER for stitches.
- 2/28/15- Two peers fought on their unit. Again, witnesses later reported this event to DRNM and stated that the Peak staff failed to respond timely to the conflict. These witnesses reported that residents, rather than staff, broke up the fight.
- 5/22/15- A resident was punched in the face by a peer and suffered a fractured nose.
- 5/25/15- A fight between two residents resulted in one resident losing two teeth. Law enforcement was called and the instigating resident was charged with Class III Battery.
- 6/21/15- Three residents assaulted a peer. Law enforcement was called to investigate the incident. The three instigating residents received Class III Battery citations.
- 7/3/15- A resident was found by staff in the darkened day room on a unit. The room's camera had been covered. The resident had been punched in the chest and had scratched, reddened skin. Four residents were found to be responsible for covering the camera and coordinating harm to the victim.
- 7/19/15 – A resident was straddled by a peer and kicked and punched in the face 4-5 times. Another resident acted as a "lookout" for staff. The victim incurred light purple ecchymosis to the anterior part of the head at the hairline.
- 7/24/15- Two residents fought during mealtime in the cafeteria. One resident incurred an open, bleeding, and swollen lip. The injured resident was taken to the ER.
- 7/25/15- A fight between two residents resulted in one resident receiving a bruise, swelling of the upper lip, and a bump on the head.

- 8/21/15 – A fight between two residents resulted in an eye injury to one of the residents. The resident required an evaluation for stitches at the El Paso Children's Hospital.
- 8/21/15- Two residents engaged in a fight, which resulted in ankle and hand injuries requiring X-rays at the hospital.

Resident concerns about fighting, bullying, and personal safety have been consistently reported to DRNM staff during site visits. During DRNM's most recent site visit on 11/2/15, four residents reported privately to DRNM that they felt threatened by other residents or were concerned on behalf of their smaller peers. One resident stated that "…kids cuss and throw things and staff never does anything about it. Fights happen a lot when staff isn't paying attention or if a code is called on a different unit. Fights are scheduled for times when they know staff is not paying attention."

Another resident reported being attacked by peers. The resident asked to be moved to another unit due to bullying and claims to have never heard back from Peak staff after the request. The resident was frustrated because bullies are reportedly only given a "Learning Experience" assignment as discipline, and no meaningful long-term safety measures were put into place.

Attempted Resident-on-Resident Violence or Aggression

Between September 2014 and September 2015, Peak staff documented 18 incidents in which residents demonstrated aggressive postures towards their peers. However, during these episodes, aggressive actions were stopped before resident safety was compromised. According to the 18 incident reports in this category, staff used a variety of interventions to keep residents safe, such using as de-escalation techniques, and when necessary, physical restraint.

Self-Harm and Suicide Attempts at the Peak

From September 2014 - September 2015, Peak incident reports reflect that there were 52 observed instances of resident self-harm or suicide attempts. In some instances, self-inflicted injuries were minor or non-existent, while in other episodes residents required immediate hospitalization and were transferred to a higher level of care. Notable instances of self-harm included:

- 2/2/15 - A resident fractured a hand during an episode of self-harm.
- 4/13/15 - A resident attempted suicide twice in one day by wrapping a sheet around the resident's neck.
- 7/4/15 - A resident overdosed on medication and became unresponsive. A unit nurse performed CPR to revive the resident, who was then taken to the ER for treatment.
- 8/12/15 - A resident used a piece of glass found outside to cut self on arm.
- 9/14/15 - A resident stabbed self with a pencil 8 times. When asked about the self-injurious behaviors, the resident reported being bullied.
- 9/30/15 - A resident found a piece of glass outside and used it to self-harm.
- In addition to the instances above, on 4/2/15, Peak management issued a memorandum to all Floor Staff regarding Resident/Patient Observation. It stated, "Our residents and patients need to be observed at all times with no exceptions. MHTs and UMs should not be behind the nurse's station for any extended amount of time...Rounds must be done all of the time; the Q15 forms should never be filled out on a guess or word of mouth from other people; staff need to visually observe each and every resident they are documenting on." (See Appendix item 2).

- Additionally, on 3/3/15, Peak management issued a memorandum to all staff regarding cell phone use at the facility. It states that "cell phones are NOT allowed on the unit at any time," presumably so that staff will remain undistracted from their supervision of residents. (See Appendix item 3).

Resident Elopement at the Peak

During September 2014-September 2015, Peak staff recorded 23 incidents of resident elopement from the Peak property. In many instances law enforcement, including U.S. Border Patrol and Sunland Park Police Department, were called to assist in retrieving residents who left the Peak campus. During some episodes, residents were gone for less than 30 minutes and returned to campus willingly on their own accord. In other instances, residents were gone in groups of three for five or more hours. In one incident detailed below, a resident eloped from a group outing and successfully evaded Peak staff and law enforcement to return home.

- 1/28/15 - A resident eloped from campus and lay down in the street. According to the incident report, the resident stated "I want to die."
- 7/25/15 - A resident eloped during a group outing to a local church service. Although the group was supervised by two staff members, the resident left and was not noted missing until the conclusion of the service. Despite efforts by Peak staff and law enforcement, the resident was able to return to their home several hours away and has not returned to the Peak since.
- 8/31/15 - Three residents eloped for five hours. The MHT responsible for supervising the residents was terminated shortly thereafter.

- In addition to these episodes, on 4/2/15, a memorandum was issued by Peak management on the subject of "Outings." It states that "any and all outings must be pre-approved. No outings are to be scheduled on the spur of the moment." (See Appendix item 4).

Other Significant Safety-Related Events

Between September 2014-September 2015, 22 miscellaneous but serious events surrounding resident safety were reported to DRNM by the Peak. Each of these incidents were labeled by Peak staff as "critical."

- 9/13/14- An allegation of resident-on-resident sexual assault was made. Law enforcement conducted an investigation and determined that events of a sexual nature had occurred between two residents. However, law enforcement deemed the actions to be "consensual [and] exploring."
- 10/8/14 - A resident was injured while being improperly restrained by a MHT. The resident incurred "redness to arms, behind ears, right shoulder, right temporal orbital area." The nurse supervisor who witnessed the incident reported that the MHT had the resident in a "chokehold" and refused to let go of the resident when ordered to do so. The incident was reported to law enforcement and the MHT was terminated the next day.
- 1/25/15 - A resident accused another resident of sexual assault. An investigation was pursued, but DRNM does not have information on the outcome of the investigation.
- 7/5/15 - A resident accused another resident of sexual molestation. Law enforcement was called and the Peak conducted its own investigation. DRNM does not have follow-up information regarding the outcome.
- 7/16/15 - A resident accused another resident of sexual assault. Follow-up information has not been made available to DRNM.

- 8/2/15 - A resident made an allegation of a sexual nature towards another resident. DRNM does not have follow-up information from the Peak regarding this event.
- In addition to these incidents, on 6/29/15, Peak management issued a memorandum to all staff regarding "Staff/Patient Boundaries." It states that "all staff must maintain proper boundaries at all times; this includes both physical and verbal boundaries. Staff must be aware of their physical boundaries with the residents and be aware of the residents' boundaries as well. Staff should not be touching the residents at any time, outside of reasons of safety." (See Appendix item 5).

Restraints at the Peak

Throughout the course of the investigation, DRNM was concerned about the use of physical and chemical restraints on residents at the Peak. Because residents consistently complained to DRNM about the use of restraints, DRNM staff conducted a full review of the restraint incident reports submitted by the Peak between February 2014 and November 2015. DRNM found problems in the following areas:

1. Staff failure to fully complete incident report forms in compliance with state regulation.
2. The questionable use of physical restraint when de-escalation techniques were not used or not used quickly enough.
3. The questionable use of restraint for incidents that did not meet the criteria of an emergency situation.
4. The frequent use of chemical restraint following physical restraints. Specifically, the use of psychotropic medications with or without residents' informed consent in situations that may not have met "emergency" criteria.

Restraint Documentation

Pursuant to NMSA 1978, § 32A-6A-10, staff are required to provide extensive documentation following each episode of restraint. Incident reports should document: any less intrusive interventions that were attempted or determined to be inappropriate before the incident, the type of behavior that prompted the restraint; the precipitating event immediately preceding the behavior; a description of the type of restraint used; the child's behavior during the restraint; the child's reaction to the restraint; the results of a de-briefing conversation with the child following the restraint; and, evidence of follow-up with the child's treatment team for modifications to the treatment plan. Further, federal regulation requires that any emergency safety intervention be "performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior and the resident's chronological and developmental age; size; gender; physical, medical and psychiatric condition; and personal history (including any history of physical or sexual abuse." 42 CFR §483.356(b).

DRNM found that the majority of incident reports submitted by the Peak failed to include all items of information required by state statute. The most commonly missed component was an adequate description of the resident's specific behaviors prior to the restraint. Non-descriptive phrases such as "patient not following directions," "patient out of control," and "patient aggressive towards staff," were used on the majority of restraint reports. Many reports also failed to document a de-briefing with the resident following the restraint, or provided very little information about the nature of the de-briefing process. Most reports did include documentation that the resident's treatment team had met to discuss the restraint within five days; however, these changes to the resident's treatment plans were typically non-substantive. For instance,

many reports indicated that the resident would simply "try to use coping skills," rather than providing any environmental or therapeutic changes to the treatment plan.

Questionable Use of Restraints

Due to poor documentation, it was difficult for DRNM to determine the appropriateness of restraints used on residents at the Peak. However, the majority of reports failed to demonstrate how or if staff used de-escalation techniques or less restrictive measures to avoid the use of restraint. Moreover, many of the reports failed to document the emergent nature of the events which precipitated the restraint. Federal regulations define an emergency safety situation as "unanticipated resident behavior that places the resident or others at *serious threat of violence or injury* if no intervention occurs…" 42 C.F.R. § 483.352 (3) (emphasis added). The NM Children's Mental Health and Developmental Disabilities Act unambiguously states "Restraint and seclusion is not considered treatment. It is an emergency intervention to be used only until the emergency ceases." (NMSA 1978 § 32A-6A-9 B.). Furthermore, an emergency situation arises only when "it is necessary to protect a child or another from imminent, serious physical harm" (NMSA 1978 § 32A-6A-10 A.). The majority of reports did not clearly show that restraint was necessary to protect the resident or others from imminent, serious physical harm. This had led DRNM to conclude that these restraints occurred under the questionable judgment of staff. Such instances included:

- 9/4/14 - A resident was restrained for 37 minutes after throwing a tennis ball at a staff member.
- 11/26/14 - A resident was restrained after kicking holes in a wall.
- 12/17/14 - A resident was restrained for "screaming at staff."
- 12/20/14 - A resident was restrained after throwing yogurt at a wall.

- 2/28/15 - A resident was restrained 3 times in a two-hour period. The report states that the resident was not following directions, yelled at staff, and refused to complete a "Learning Experience" assignment.
- 5/17/15 - Two residents eloped from a group activity and hid underneath a building on the Peak campus. Staff crawled underneath the building to forcibly remove the residents. Both residents appear to have been restrained while underneath the building and again after resurfacing. DRNM spoke with the two residents after the event, and both reported being handled in a rough and physically inappropriate manner by staff.
- 7/22/15 - Two residents were involved in a verbal altercation. Staff separated the residents. However, after being removed from the unit, one of the residents was restrained. There was no documentation showing why restraint was necessary after the residents had already been separated.
- 9/3/15 - A resident was restrained for "inappropriate language/verbal aggression towards staff."
- 9/17/15 - A resident was restrained for showing anger when a pencil was taken away. No unsafe behaviors were reported.
- 9/26/15 - A new resident hid in a closet and refused to come out. The incident report read that the resident was "removed for safety." When the resident became combative with staff, the resident was restrained.
- 10/26/15 - A resident was restrained for swinging a stick during outdoor recreation. It does not appear that the resident was swinging the stick towards anyone or attempting to self-harm.

Chemical Restraint

Between September 2014 and September 2015, Peak staff recorded 105 episodes in which physical restraints resulted in chemical restraints. During these incidents, residents were injected with psychotropic medications while being physically restrained or immediately thereafter. At the time of publication of this report, DRNM does not have access to all of the records of residents who received emergency injections. However, in accordance with NMSA 1978 § 32A-6A-17 (L), following the use of psychotropic medications in emergency situations, the prescribing clinician must provide a written report that explains 1) the nature of the emergency, and 2) the reasons that no treatment less restrictive than administration of psychotropic medication without proper consent would have protected the child from serious harm. To that end, the Peak is required to either:

a. Have documentation of prior informed consent from residents or their guardians to receive emergency psychotropic medications; or,

b. Have documentation in each resident's record from the ordering clinician regarding the nature of each emergency and the reasons that psychotropic medication was necessary.

DRNM asserts that failure to meet one of these conditions would constitute battery on a child under New Mexico law.

Conclusions and Recommendations

DRNM contends that Strategic Behavioral Health failed to provide a safe environment for the adolescent RTC residents at the Peak from September 1, 2014 - September 30, 2015. During the 13-month period of focused review, Peak staff repeatedly failed to stop residents from harming each other and themselves. The failure to monitor, assess and prescribe proper

conditions for resident safety constitutes a pattern and practice of neglect pursuant to 7.20.11.7 NMAC CL, (2-4). DRNM contends that Strategic Behavioral Health failed to:

a. take reasonable precautions necessary to prevent damage to the health or safety of its clients,

b. carry out a duty to supervise or properly control the provision of treatment,

c. use restraint only when a resident was behaving in a way that could cause either the resident or another person imminent serious physical harm, and

d. failed to take reasonable actions that would prevent the physical abuse, sexual abuse, or sexual exploitation of a client.

Furthermore, adolescent residents at the Peak are to be provided the protections of the NM Children's Code at NMSA 1978 § 32A-6A-12 (7), which states that residents in RTCs are entitled to "a humane psychological and physical environment." The frequency of resident-on-resident violence reported above, in conjunction with perpetual incidents of self-harm, elopement, and sexual allegations, clearly pinpoint the Peak's failure to provide a safe and humane psychological and physical environment. To that end, DRNM is deeply concerned about the safety of residents on the adolescent RTC units at the Peak under the care of Strategic Behavioral Health. In light of these findings, DRNM supports the efforts of CYFD and LCA in imposing an Admissions Hold, Expansion Hold, and Compliance Monitor for the Peak while Strategic Behavioral Health attempts to comply with its current Directed Action Plan under 7.20.11.9 (B)(4)(f) NMAC.

DRNM concurs that all of the Peak's policies and procedures and staff interventions be grounded in the obligations articulated in the Children's Mental Health and Developmental Disabilities Act. In particular, DRNM believes that the Peak must be required to:

1. Create a safe, humane and therapeutic environment to eliminate resident-on-resident aggression, bullying and sexual assault,
2. Protect children from threats of or acts of self-harm and make therapeutic adjustments to address such threats,
3. Use restraints only in cases of imminent threats of harm to the resident or others using proper de-escalation techniques and interventions, doing so in a manner that addresses all the factors required by federal regulation and state law,
4. Document all incidents of restraint in the manner required by the Children's Mental Health and Developmental Disabilities Act,
5. Conduct post-restraint treatment planning to revise treatment plans as necessary to eliminate the need for restraint,
6. Assure clinically appropriate use of medication so that residents are not subjected to unnecessary or excessive medication.

In addition, DRNM:

1. Encourages Peak Behavioral Health to contact Beth Caldwell with the Building Bridges Initiative to conduct a follow up on-site review of the program to provide consultation and technical assistance.
2. Supports the refusal of any of the four NM Centennial Care MCOs to refer consumers to the Peak.
3. Encourages adolescent consumers and their guardians who are seeking residential treatment options to consider alternatives to the Peak.
4. Encourages judges and other court officials to seek alternatives to the Peak when ordering residential treatment for adolescents.

Appendix Items

1. Peak Incident Reports, September 2014 – September 2015

2. Peak Memorandum re: Resident/Patient Observation

3. Peak Memorandum re: Cell Phones

4. Peak Memorandum re: Outings

5. Peak Memorandum re: Staff/Patient Boundaries

	Resident-on-resident violence/aggression	*Attempted* resident-on-resident violence/aggression	Resident-on-staff aggression/violence	Self-harm or suicide attempt	Elopement	Other significant incidents	Total incidents
Sep 2014	2	2	14	5	1	1	**25**
Oct 2014	1	0	8	4	5	1	**19**
Nov 2014	7	3	18	6	1	0	**35**
Dec 2014	9	1	16	2	3	0	**31**
Jan 2015	6	0	3	1	1	1	**12**
Feb 2015	4	0	4	2	0	0	**10**
Mar 2015	4	1	5	3	1	0	**14**
Apr 2015	3	0	4	4	1	0	**12**
May 2015	2	1	6	3	3	2	**17**
June 2015	7	1	5	6	0	1	**20**
July 2015	16	1	2	0	2	3	**24**
Aug 2015	15	4	18	9	5	1	**52**
Sept 2015	4	4	17	8	0	12	**45**
Year total	**80**	**18**	**120**	**53**	**23**	**22**	**316**

Peak Incident Reports

September 2014 – September 2015

Appendix item 1

04/02/2015

MEMORANDUM

Attn: All Floor Staff
Re: Resident/ Patient Observation

Our residents and patients need to be observed at all times with no exceptions. MHTs and UMs should not be behind the nurse's station for any extended amount of time; their assigned area is on the unit hall or dayroom with the residents. Rounds must be done all of the time; the Q15 forms should never be filled out on a guess or word of mouth from other people; staff need to visually observe each and every resident they are documenting on.

Staff are to remain on their assigned unit at all times. With the exception of going on a break or using the restroom, staff need to be in their assigned area. This is for the safety of staff and resident alike.

If staff is observed falsely documenting, not conducting regular rounds, or leaving their assigned unit, disciplinary actions will follow.

If you have any questions, please call your Milieu Manager.

Thank you,

Cyrus G. Condran
Milieu Manager

Appendix item 2

March 3, 2015

Memorandum

Attn: All Staff
Re: Cell Phones

Cell phones are NOT allowed on the unit at any time. Staff are not to use their cell phones while on the units during their shift. Cell phones are to remain out of sight at all times; staff may check their phones during their breaks while off the unit.

If staff is concerned about issues outside of work, the hospital has landlines that can be reached 24-hours a day 7 days a week.

Any staff observed utilizing their personal cell phones on the units will be subject to disciplinary actions.

If you have any questions or concerns, please contact your DON or Milieu Manager.

Thank you

Appendix item 3

04/02/2015

MEMORANDUM

Attn: All Floor Staff
Re: Outings

Any outings that this facility has will be posted on the outings calendar. Any and all outings must be pre-approved. No outings are to be scheduled on the spur of the moment. If you have ideas for outings or would like to see something, please inform your Rec Tech or Milieu Manager who will then take the appropriate actions to get the outing idea approved.

When going on an outing, only those team member who have been through the driving instruction course and are authorized to drive a company vehicle are allowed to drive. If there are not enough drivers for an outing, the outing may not occur until more drivers are located. If you are found to have utilized a company vehicle without permission or are not an authorized driver, there will be disciplinary actions.

We do our best to ensure that outings do not only happen on any particular shift or day and that every team member has an opportunity to participate. If you have any issues with the outings or scheduled outings, please contact your Milieu Manager.

If you have any questions, please call your Milieu Manager.

Thank you,

Cyrus G. Condran
Milieu Manager

Appendix item 4

June 29,2015

Memorandum

Attn: All Staff
Re: Staff/ Patient Boundaries

All staff must maintain proper boundaries at all times; this includes both physical and verbal boundaries. Staff must be aware of their physical boundaries with the residents and be aware of the residents' boundaries as well. Staff should not be touching the residents at any time, outside of reasons of safety.

Verbal boundaries include yelling, threatening, coercing, or degrading comments. Staff should be aware of how they are speaking with residents and ensure that they are using proper verbiage, values, and terms.

Included with boundaries is favoritism; staff should treat all residents the same. Staff should not give the perception of favoritism at any time. Staff can avoid giving the wrong impression by maintaining appropriate physical and verbal boundaries at all times.

All residents are to be treated with the same respect and encouragement. They should all be given the same opportunity to advance and be able to participate in the outings and activities.

If you have any questions about appropriate boundaries, please contact your Milieu Manager.

Failure to maintain appropriate boundaries will result in further disciplinary actions.

Thank you,

Cyrus G. Condran
Milieu Manager

Appendix item 5