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V 000	INITIAL COMMENTS A Complaint Survey was completed 03/21/18. Complaint intakes #NC00136444 & #NC00136343 were substantiated and Complaint intakes #NC00135377 & #NC00135767 were unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Level III for Adolescents.	V 000		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and	V 296		

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V 296	Continued From page 1 (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure two of three audited direct care staff (#6 and #8) were awake as the physical client census at the home was seven. The findings are: Review on 03/19/18 of the facility's records revealed: -Weekend staff operated using two 12-hour shifts: 8a-8p and 8p-8a - Seven clients (#2-#8) were physically at the group home on Sunday 02/25/18 - Staff #6 and Staff #8 were assigned to work on Sunday 02/25/18 from 8p-8a Monday 02/26/18 Review on 03/20/18 of staff #8's record revealed: -Hire Date: 11/15/17	V 296		

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V 296	Continued From page 2 Review on 03/20/18 of staff #6's record revealed: -Hire Date: 06/26/17 Review on 03/06/18 of client #8's record revealed: -Admission Date: 09/22/17 -Date of Birth correlates with age 15 -Diagnoses which included Oppositional Defiant Disorder and Post Traumatic Stress Disorder -Assessment dated 09/22/17 noted history of elopement -Treatment plan dated 09/14/17 with goals that included adhere to rules of Level 3 residential placement no elopement attempts. Strategies outlined were for group home staff to monitor client at all times, monitor her mood disorder symptoms and encourage her to use coping skills, help her identify different emotions and ways to express them appropriately, utilize skills learned in therapy and provide team with progress updates. -No elopements noted between October 2017-February 24, 2018 from the group home. One elopement noted in September 2017. Several unsuccessful attempts were made to interview client #8. Due to hospitalization between 03/06/18 and 03/21/18, client #8 was not able to be interviewed. Review on 03/07/18 of the North Carolina Incident Response Improvement System records revealed the following about client #8 : -02/25/18, client had been caught inappropriately using her alternative school laptop...client had stolen her school laptop from the staff's office and was attempting to utilize in her bedroom to facetime men...staff discovered	V 296		

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client using the laptop during a routine check and retained the tablet..staff educated the client on the dangers of seeking older men, giving out her personal information such as the residential placement's address and attempting to link up with men to be sexually active... client was able to contract for safety and agreed not to steal electronics, utilize face book again to contact men and to really focus on her school work...later in the shift, client eloped from the group home.

Review on 03/15/18 of police records revealed the following:

-02/26/18 at 5:31a, received call for missing juvenile (client #8)

-Police Report dated 02/26/18 at 6a indicated the officer spoke with staff #8....staff reported client #8 "went out the window because the doors had chimes and it didn't go off and we would have heard it...she has ran away from here before and we found her at the hotel near [streets]. We have already checked the hotel and they did say that they saw her come in around midnight last night." *Note distance between the hotel and the group home is approximately 2 miles or a 5 minute drive.

-Police Report dated 02/26/18 at 7:57a of supplementary information of the officer's visit at the local hotel. "When I arrived I spoke with the front desk employee who stated the missing juvenile (client #8) was at the hotel the night prior. I reviewed the video and it shows the missing juvenile entered at 22:37 (11:37 PM) hours. She walks right through the lobby towards the stairs. She roams the first and second floors before getting stopped by security. She was never seen going into a room. She told staff that she was homeless When they started calling the police, the juvenile left in an unknown direction." It was unknown if client #8 left on foot or other means of

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transportation.

During interview on 03/19/18, staff #11 reported:
-She worked on 02/25/18 from 8a-8p. Management informed her to monitor client #8 closely as she had threatened to runaway as a result of her being caught inappropriately using the school computer. "We allowed her some space but we remained within constant visual eye contact on her. That information was relayed to the oncoming shift."

During interview on 03/13/18, staff #8 reported:
- She worked all shifts at the group home
-On the overnight shift, 15 minute bedchecks were completed. A bedcheck was described as "go to every room and make sure each of them are in their assigned place and safe. I go inside the room. We make sure they are breathing. We put it in our notes that we check on them and we do a walk through."
-- Confirmed she worked Sunday 02/25/18 from 8p through Monday 02/26/18 at 8a. Staff #6 was also on the same shift. She and staff #6 took turns being awake on the shift. She remained awake during the first half of the shift and staff #6 remained awake the second portion of the shift. She thought it was okay to sleep while on duty.
-The morning of 02/26/18, client #8 eloped from the group home. "I checked the room every 15 minutes and she was in that bed. So, when 5a came, she went out the window. We start getting the kids up at 5a. I noticed she was not in the bed. The window was unlocked. She had to pull it (the window) down as it was not left up, the window screen was up. We sit in the hallway... On my checking, she was there." She called the police to report client #8 missing. When she arrived at 8p on 02/25/18, outgoing staff did not share any information of concern with her

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regarding the clients. Upon arrival on the shift, she was not informed client #8 needed to be monitored closely or of any concerns regarding any clients at the home.

During interview on 03/20/18, staff #8 reported the following about the night of 02/25/18-the morning of 02/26/18:

-She could not sleep well anywhere other than her bed.

-She remained awake on duty and did not sleep the entire shift. She and staff #6 "split the shift." On the 3:30a-6:30a portion of her shift, she just "chilled" and remained awake. Staff #6 was in the foyer area in a chair.

During interview on 03/14/18, staff #6 reported:

-She regularly worked the overnight shift. During the week, she worked 12 midnight-8a and on weekends, the overnight was a 12-hour shift. Management provided staff only their specific work shift not information of the other staff assigned on duty.

-She described the 15 minute bedchecks as "the light on, go to the bed and make sure they are in there." That was always the process. No changes had been made.

- At the beginning of the 8p shift on 02/25/18, she spoke with outgoing staff... was informed client #8 said she was going to run away, which she did regularly. Initially, all clients were up as bedtime started 8:30p. The clients prepared for bedtime and everyone was settled down by 10:30p. Two roommates had disagreements and it took a while for them to settle down.

-"We (staff #6 and staff #8) took turns sleeping. I slept the first half...11:30p-3:30a, I slept....I was awaken by [staff #8] one time because she had to go to the bathroom and to make sure someone was up. I woke up around

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3:30a and did my check...At 4a, I did another check and noticed the light in the bedroom was on. I woke up [staff #8], she called management." It took a few minutes to get a response. Management called back within 15 minutes or so. Then staff #8 called the police. As the clients were getting prepared for school, the police arrived.

-Since the 02/25/18 elopement, no changes have been made as a result of the elopement. Management did ask about the circumstances of the elopement.

During interview on 03/20/18, staff #6 reported the following about the night of 02/25/18- the morning of 02/26/18:

-Staff #8 was not asleep on shift. When asked to clarify her 03/14/18 interview statement she had to wake up staff #8 to call management, she indicated she did wake up staff #8. She verified staff #8 was asleep.

-She completed bedchecks on clients between 11:30p-12 midnight. She and staff #8 talked and sat on the couch. When asked to clarify her 03/14/18 interview statement she slept beginning 11:30p, she reported she slept from 12 midnight and woke up between 3-3:30a.

During interview on 03/08/18, the Director reported:

-Client #8 went out the window and put pillows in the bed to hide her elopement on 02/26/18. She was found in her hometown (approximately three hour drive time from the group home) on 03/05/18 when she went to her mother's house for more clothes. She was hospitalized in that area. Client #8 would require a higher level of treatment than a Level 3 facility as she wants to leave and run.

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V 296	Continued From page 7 During interview on 03/20/18, the House Manager reported: -Random checks via calls and pop up visits were completed on the night shift and every shift at least twice a month for the group home. The random staff checks resulted in no episodes of staff sleeping -The night of 02/25/18, client #8 exhibited behaviors as she had been found earlier that day using the home-school computer on the Internet chatting with a young man. She had threatened to run away. The 8a-8p staff were told to monitor her closely. That information should have been relayed to the 8p-8a staff as well. During interview on 03/20/18, the Supervisor at the hotel reported: -The morning of 02/26/18, the police came to the hotel, reviewed the video tape of a missing juvenile (client #8) that was at the hotel the night of 02/25/18 and made notations. The video has been erased as of 03/02/18 but the police documented the specific times in their report as well as the activity of her visit. -Per his recollection of the 02/25/18 video, client #8 entered the hotel through the front door near the change of shift, did not enter a room. He could not recall the specific time on the video. However, the night auditor shift started 11p and the evening clerk was getting off duty. Both staff provided him statements regarding seeing client #8. He estimated client #8 would have been at the hotel between 10:30p-11:30p for both the night auditor and the evening clerk to have been together when she was seen. During interview on 03/21/18, the night clerk at the hotel reported: -She did not recall the specific time she saw client #8 on 02/25/18. She worked from 3p-11p.	V 296		

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V 296	Continued From page 8 However, she initially observed client #8 during the hours she was the only clerk on duty Then she observed client #8 when she and the night auditor were on duty together at the exchange of shift. -Police would not have been called because client #8 did not cause a disturbance at the hotel. During interview on 03/20/18, the Director reported: -In regards to the 15 minute bedchecks, the checks could look different for every house, staff person or client. Some of the clients complained of the over head room light being turned on during the night. She described a bed check as walking into the bedroom, using the hallway light to see inside the bedroom and looking to see if a person was in the bed. She did not want staff to physically touch the clients or pull back the bedding covers. -Prior to 03/20/18, she was not aware of the discrepancies in the staff statements regarding being awake or sleep. Both staff should be awake during clients' sleeping hours. -She was not aware client #8 had been at the hotel prior to 12 midnight on 02/25/18. She was aware client #8 was at the hotel but thought it was on 02/26/18. This deficiency is cross referenced into 10A NCAC 27D. 0304 Protection from Harm, Abuse, Neglect and Exploitation (V512) for a Type A1 rule violation.	V 296		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm,	V 512		

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V 512	Continued From page 9 abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record review and interview, two of three audited staff (#6 and #8) subjected seven of seven audited clients (#2-#8) to neglect. The findings are: Cross reference: 10A NCAC 27G.1704 (V296). Based on record review and interview, the facility failed to assure two of three audited direct care staff (#6 and #8) were awake as the physical client census at the group home was seven. Review on 03/20/18 of the facility's Plan of Protection dated 03/20/18 and submitted by the Director revealed: "-What immediate action will your facility take to ensure the safety of the consumers in your	V 512		

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care? The agency will immediately send out a written communication re-educate all staff of the ratio, crisis protocol, mandatory staff training date and 15 minute bed check rules. The agency will implement a policy that requires the staff to sign off on an intervention form indicating that they have abided by the rule and that they fully understand. The agency has defined AWAKE Staff Room Check as follows: both staff shall be awake at all times during the night shift. One staff will physically stand in the hall way point of entry to avoid a client from walking/running out of the front or back door, while the 2nd staff will physically complete a walk through and look into each client's room to ensure their physical presence & safety. The AWAKE staff will utilize one of the following interventions located on the NBHC (New Beginning Health Care) 15 Minute Bed Check Form. Male staff on shift are to physically stand in the hall way point of entry to avoid a client from walking/running out of the front or back door, while the 2nd staff will physically complete a walk through and look into each client's room to ensure their physical presence & safety. When there are two female staff working, one staff will take the lead to physically complete a walk through and look into each client's room to ensure their physical presence & safety. The Director will contact the NC Health Check Registry and report the names of the staff that were found out of compliance 10ANCAC27D.0304.

-Describe your plans to make sure the above happens. The agency sent out a mass communication text on 03/20/18 that requires an individual reply of receipt from each staff pertaining to the receipt of the written communication re-educate all staff of the ratio, protocol and 15 minute bed check rules. A training will also be scheduled for 4-11-18 to

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focus on crisis training, emergency measures to takes, errors made in the past, what to avoid and role play scenarios. In addition each house manager will have the responsibility of calling and completing random checks to ensure the alertness of the night shift staff."

The facility's census on 02/25/18 was seven clients, thus requiring two awake staff at night. Earlier in the shift, client #8 was caught on the internet face-timing men for sexual liaisons and had threatened to run away. Management had advised staff to closely monitor client #8. Overnight on duty staff (#6 and #8) decided as clients' #2-#8 slept, to "split" the shift. "Split" the shift meant staff #6 slept while staff #8 monitored clients and vice versa. Staff #6 and staff #8 described different methods of bed checks from eyes on the person to walking inside the bedroom and different time intervals 15 or 30 minutes for monitoring. During the night, client #8 eloped. Interviews from staff #6 and staff #8 revealed no ability to verify a specific window of time in which client #8 had eloped from the home as they thought she was in bed between 8:30p-4a based on their bed checks. Video from a local hotel showed client #8 entering the hotel around 11:37p on 02/25/18. For 7 days (02/26/18-03/05/18) client #8 was unaccounted for by the group home staff and ended up in her hometown which is an approximate three hour drive from the group home. These failures of sleeping while on duty, bed checks conducted inconsistently and lack of monitoring by staff #6 and staff #8 resulted in serious neglect. The violation constitutes a Type A1 rule violation and must be corrected within 23 days. An administrative penalty in the amount of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be

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V 512	Continued From page 12 imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		