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V 000	INITIAL COMMENTS As a result of additional information received during a settlement conference on June 6, 2018 this statement of deficiency was amended on June 6, 2018. An annual survey was completed 1/3/18. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600D Supervised Living for Minors whose Primary Diagnosis is Substance Abuse.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement a plan with goals and strategies for high risk behaviors identified in the assessment, affecting 1 of 1 audited former client (FC#11). The findings are:

Review on 1/2/18 of FC #11's record revealed:
-15 year old female admitted 11/6/17.
-Diagnoses included Cannabis use disorder, severe; alcohol use disorder, severe; sedative, hypnotic or anxiolytic use disorder; moderate; oppositional defiant disorder.
-Client eloped from facility 11/21/17.
-Administratively discharged 11/24/17

Review on 1/2/18 of FC #11's clinical assessment dated 10/17/17 revealed:
-Assessment completed by Licensee staff prior to admission.
-"Reasons for Seeking Services ... Presenting Problems: [FC #11] has a severe substance use issue, with a history of running away and human trafficking concerns. [FC #11] is currently locked up for running away."
-Assessment question, "Have you ever lived on the street or in a shelter?" Response documented, "Yes."
-FC #11 had been injecting methamphetamine as her main substance of choice.
-FC #11 was in detention due to running away. She was a "frequent runner." Her legal charges included communicating threats, truancy,

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runaway, and probation violations.
-FC #11 had associated with older men on a regular basis which had given cause to believe along with other contributing factors that she was part of a human trafficking ring. FC #11 would not "outright confirm this, nor does she outright deny it."
-FC #11 was a "cutter." This started at age of 11. She had not cut since Spring 2017.

Review on 1/2/18 of FC #11's treatment plan dated 10/30/17 and 11/6/17 revealed:
-FC #11 was in detention awaiting placement due to her history of running away.
-3 residential goals addressed: (1) abstinence from all substances; (2) attending school to obtain her high school diploma; and (3) develop coping skills to manage her mood and regulate her emotions.
-The 4th residential goal read, "[FC #11] will refrain from any activity or behavior that could possibly result in further legal involvement as evidenced by complying with all treatment recommendations, having zero incidents of inappropriate behaviors and/or illegal activities and remaining abstinent from all substances."
-No specific goals to refrain from elopement behaviors.
-No strategies listed for any goals to prevent elopement behaviors.

Review on 1/2/18 of the North Carolina Incident Response Improvement System (IRIS) report for FC #11 dated 11/24/17 revealed:
-11/21/17 FC #11 eloped from facility at 5:20 pm.
-"At approximately 5:20 pm [FC #11] made her nightly phone call to her mother. She was disrespectful and demanding to her mother, ultimately hanging up on her and going to her room, slamming her bedroom door behind her.

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Staff allowed [FC #11] to have five minutes to cool down before going into her room at 5:28 pm to check on her. Staff found [FC #11's] window open and [FC #11] was not present in the room. Staff checked the premises and then followed the crisis plan."

Review on 1/3/18 of the FC #11's police report dated 11/21/17 revealed:
-Call received on 11/21/17 at 5:57 pm of a runaway juvenile from the facility.
-Officer arrived at the facility at 6:06 pm.
-Property searched, juvenile not found.
-11/28/17 follow up investigation with Program Supervisor and the Child and Family Therapist. Staff had no new information on FC #11's elopement. Staff said, "[FC #11] had stated that she was going to see her nephew for Thanksgiving and that no one could stop her."
-Local police had contacted FC #11's aunt, oldest sister, and the police in her home town approximately 240 miles from the facility. There had been no reports of FC #11 making contact or being seen in that area.
-Police from FC #11's home town reported they had 8 cases of FC #11 running away within the year. She was difficult to find. She liked to stay with her older sister who was currently homeless and difficult to locate. When she stayed with this sister FC #11 would be "prostituted out on Craigslist by the sister."
-There had been no reports that FC #11 had been found.

Unable to interview FC #11's guardian; no response to telephone message left 1/2/18 at 3:34 pm.

Interview on 1/3/18 Staff #11 stated:
-He was 1 of 2 Residential Counselors working

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the evening shift when FC #11 eloped. The other counselor was Staff #8.
-He was monitoring FC #11 while she was on the phone with her mother. FC #11 was disrespectful; he heard FC #11 say, "No you listen to me, this is what we are going to do. Get this through your tiny little head what we are going to do." He heard FC #11 say to her mother that she (the mother) was coming to get her (FC #11) and they were going home for Thanksgiving. FC #11 got mad and slammed the phone down, ran to her room and slammed her bedroom door. He talked with Staff #8 and decided to give FC #11 about 5 minutes to calm. He waited about 4 minutes, then went to her door, knocked, and entered. Her roommate was in the room and it was obvious FC #11 had just eloped. Staff #8 went to look for FC #11. The Program Supervisor and FC #11's mother were called. When Staff #8 returned, he "switched off" and did a search. It was dark outside. "Darkness was falling when she left." She was on the phone maybe "5:07'ish" and was on the phone less than 5 minutes.
-Staff had read her assessment and knew she had a history of running away, living on the streets, and living with "guys."
-When asked if there were strategies in place to prevent FC #11's running away behavior, Staff #11 stated staff were aware she had a history of running away, but there was a limitation given the facility was unlocked . "We even tell clients this is not a locked down program, you make choices. We tell them if they are going to leave, leave by the front door, it's not locked, don't break the windows. We talk a lot about making wise choices and consequences. If a client cannot do this, this may not be the level of care for you. Typically if clients tell staff they do not want to be here, we tell them they have made a choice and if they do not want to be here we will make contacts

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of others involved and refer you elsewhere."
-Staff kept a close eye on FC #11 when they were outdoors. Especially if he saw her near the fence, he would go over and talk with her. When asked about strategies when they were inside the building, Staff #11 stated "At some level when clients are admitted they should consider wether or not they can be successful in this environment."
-He knew there were questions about FC #11 going home for Thanksgiving, but he had not been made aware that she would not be allowed to go home.
-Clients were allowed privacy when in the bathroom and when changing clothes in their room. Policy was "eyes on" at other times. When FC #11 slammed her door staff had to make a clinical decision whether to give her time to de-escalate, then try to talk to her, or not. He made the decision to give her some time. He would give clients up to 5 minutes to change clothing with their door closed, so giving her 5 minutes seemed reasonable.
-He heard FC #11 say to her mother on the phone that she was going home to see her sister and nephew/niece and no one was going to stop her.
-She could not have taken much of anything with her. They were worried that FC #11 did not have adequate clothing when she left. Clients were not allowed to keep money.

Interview on 1/3/18 Staff #8 stated:
-She was working with Staff #11 the night FC #11 eloped. She (Staff #8) was on "kitchen duty" and Staff #11 was at the staff desk monitoring clients' phone calls. FC #11 was on the phone with her mother. She could hear FC#11, and she was in an argument about therapeutic leave. FC #11 was yelling at her mother, cursing, and hung up

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the phone. When this happens they would typically give clients a couple of minutes to cool down. When they checked on FC #11 she had gone out the window. She (Staff #8) went outside, drove around the area, called the Program Supervisor. She could not find FC #11. Staff called FC #11's mother and the local police. Time between her elopement and police called was probably less than 1 hour, probably 30-45 minutes.
-She was not aware of any strategies specific to FC #11's for her running away behaviors.
-Staff were told FC #11 had a history of running away and that she was "good at it;" she knew how not to get caught, and she was at high risk for running away. FC #11 even talked about it when she was here.
-There had been no changes made with policies or procedures since this had occurred.
-When asked if she could think of anything else that could have been done, she stated they could have called the police quicker, "Our policy is that we are not a locked facility and if you go that is on you. This is explained to the clients, this is their choice and they will have to deal with the consequences."
-Since working there, there had been a lot of elopements. Those clients had either been found by local police or gotten arrested.

Interview on 1/2/18 the Child and Family Therapist stated:
-She had talked with FC #11 about elopement. FC #11 shared that her mother made her sleep on the floor and was "ok" with her prostitution as long as she would bring back drugs. She was admitted here because it was away from her home town, and not in a major city. The FBI (Federal Bureau of Investigation) was involved due to the human trafficking situation. She had no

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V 112	Continued From page 7 doubt FC #11 was a part of a ring. FC #11 older sister was involved in the trafficking. FC #11 said her sister was helping to "pimp her." She (Child Family Therapist) made a DSS (Department of Social Services) report about FC #11's mother with FC #11 also on the phone during this report. In the end DSS was not going to let FC #11 go back to her home town area for the holiday. FC #11 wanted to see her sister and nephew. -FC #11 had been involved on the streets since she was 13 years old. "There is but so much we could do to prevent her from leaving because this is an unlocked facility." Interview on 1/2/18 the Qualified Professional stated: -There are no window or door alarms. She thinks this had been discussed prior to her hire, but she had no information about a decision regarding alarms. -FC #11 was upset with her mother. -The pre-admission process for the facility included an assessment and the development of the PCP (Person Centered Plan). The PCP was re-visited when a client was admitted. -FC #11's assessment was done at a another facility owned by the licensee located in a town closer to FC #11's home town for the client's convenience. The PCP was started with the pre-admission assessment, and re-visited on admission. -There was no specific goal in FC #11's plan addressing her risk for elopement, but she would consider elopement to be part of the client's goal, "I want to get off probation." They addressed coping skills with her. All of the clients had some risk of elopement. "We are an unlocked facility." -The general policy was client bedroom doors were always open unless the client was "changing."	V 112		

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V 112	Continued From page 8 -FC #11 was mad because she could not go back home for Thanksgiving. She talked to her mother the day before she was to start therapeutic leave with her mother in the town approximately 30 miles south of the facility. Interview on 1/2/18 the Program Supervisor stated: -There had been 1 Level 2 incident in the past 90 days. FC #11 had eloped. -They never used restraints in the facility. Staff are skilled at de-escalating situations and avoided the use of restraints. -Police were called when FC #11 eloped. -Police would not issue an Amber Alert. Police stated this did not meet criteria because she left on her own and no one had picked her up. -To her knowledge, FC #11 had not been found. Interview on 1/3/18 the local Police Chief stated: -The police responded to a juvenile elopement at the facility on 11/21/17. -They believed her plan was to return to her hometown. -The police had made several contacts with the police in FC #11's home town. -They have no evidence that she has been seen or anyone has heard from FC #11. -They follow state criteria to issue Amber Alerts, and she did not meet this criteria.	V 112		