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By DHSR - Mental Health Lic. & Cert. Section at 11:15 am, Jan 03, 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-371	A. BUILDING: ______ B. WING ______	C 11/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEVEL III	2 COMPTON DRIVE ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on November 20, 2018. The complaint was substantiated (Intake #NC00144542). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000	**10A NCAC 27G .0205** **10A NCAC 27G .1701** A clinical case review is completed for each client on a monthly basis, at a minimum. The review is facilitated by the assigned Clinician and includes all cottage staff. The document that guides this process was revised in October 2018, with implementation in November 2018. The revised document is designed to be a "living document": information is updated and added to the original document at each review to create a clear progression of treatment, emerging needs and implementation of intervention strategies. Additionally, the revised document includes detailed, comprehensive crisis planning.	11/7/2018
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	This document was revised again in December 2018 to include: 1. Prompt under each treatment goal for goal revision 2. Identification of additional treatment needs and immediate intervention strategies to address these needs. 3. Documentation of the next CFT Meeting, during which the identified goal revisions and treatment needs will be discussed and the PCP will be updated to reflect the recommendations. The clinical case review process is designed to elicit observations of client behaviors and efficacy of interventions from all staff who have engaged with each client and use this information to drive the formal treatment planning that occurs in the monthly Child and Family Team Meetings and is documented on the Person-Centered Plan. Eliada's Clinical Director will review each	12/31/2018

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V 112	Continued From page 1	V 112	Clinical Case Review document weekly to ensure thorough completion and appropriate use of this documentation tool.	12/31/18
	This Rule is not met as evidenced by: Based on record review and interviews the facility failed to develop and implement goals and strategies to address the behaviors effecting 2 of 3 current clients (#1, #2) and 1 of 1 former clients. The findings are:		Person-Centered Plan development: Eliada's Clinical Director and PQI Director have revised Eliada's PCP Development Guide which includes specific interventions for each service delivered through the agency and guidance for how to individualize and document strategies on the PCP.	12/3/2018
	Client #1: Record review on 11/7/18 and 11/8/18 for Client #1 revealed: -Admitted on 8/16/18 with diagnoses of Post-Traumatic Stress Disorder and Oppositional Defiant Disorder.		Training will be provided to all Clinicians and Cottage Supervisors on PCP development and documentation in January 2019.	1/22/2019
	-Transition/Discharge Summary dated 8/1/18 completed by a prior service provider indicated " ...client had had a history of suicidal thoughts and depression and anxiety. Mother reported that she lies a lot, used marijuana, and was often truant ...client does not seem to understand consequences to her actions. Client would go with her ex-boyfriend for days without letting me know where she was ...Client had some success retrieving credits during a summer school program, yet has left several times without permission and has frequently smoked marijuana during lunch breaks. Client continues to leave the home without permission and does not comply with mothers expectations in the home ...client needs to address her depression and anxiety which is also leading to increased marijuana use ...Client is a rising senior...has had significant truancy issues over the past year ..."		Eliada has invested in the Seeking Safety Group Therapy program, which address both trauma and substance use. This program will be implemented in Eliada's Level III programs by February 2019. Eliada Clinician's will document group therapy sessions in an individual progress note for each student participant. Eliada's electronic therapy note has been updated for this purpose. Expectations for group therapy documentation will be provided for all Clinicians in January 2019.	11/15/2018 2/28/2019 12/31/2018 1/4/2019
	-Comprehensive Clinical Assessment Addendum dated 8/3/18 indicated " ...Educational/Social Issues: ...Client attended mini mester and completed all her credits in one week, yet would		**10A NCAC 27D .0103** Eliada's shift note has been revised to include a Security Scan section. This section documents: 1. Type of Scan A. No scan completed B. Routine security scan C. Scan completed for cause D. Client refused scan 2. Reason for Scan	1/2/2019

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V 112	Continued From page 2 be late or come back high after lunch. Client is unable to maintain responsibility for any significant amount of time ...Client has been known to smoke marijuana daily, although she reports reducing her daily intake to 1-3 joints a day ..." -Intake Summary dated 9/13/18 indicated " ... [Client #1] has been truant from school, home, and work ...[Client #1] feels she is unable to make good decisions about her whereabouts, which poses ongoing risk of drug use, sexual exploitation, and physical violence. Current behaviors include: truancy, leaving home without permission, drug use, lying, lack of medication compliance, DJJ (Department of Juvenile Justice) ...She is reconnecting with negative people who were in her life prior to her stay in a 3-day assessment center program ...Reason for Placement: ...Run Risk: Has run from home 4X in the past year. These were planned runs. She has been gone for 2-10 days ...she goes with her boyfriend ...Substance Abuse: Marijuana, alcohol, Xanax ..." Review on 11/8/18 of the Treatment Plan dated 7/30/18 for Client #1 revealed: -Goals included "(1) [Client #1] will demonstrate an improvement in post-traumatic stress symptoms as evidenced by: decreased avoidance behaviors, decreased irritability, elimination of angry outbursts, and expression of wider range of emotions, and (2) [Client #1] will demonstrate an improvement in symptoms of oppositional-defiant/disruptive behavior characteristics as evidenced by: Increased impulse control, improved outward control of own triggers, increased compliance with rules and structure, increased honesty and increased ability to accept responsibility for behavior." -Strategies/Interventions for both goals were "To	V 112	A. Environmental Safety (Routine) B. Suspected Contraband C. Observed Behavior D. Communicated Threat E. Elopement/Return from unsupervised activity 3. Scope of Scan A. Person B. Room C. Bag 4. Procedure for Scan A. Verification of protocol followed 5. Findings of Scan A. None B. Description of property seized C. Disposition of property seized D. If items found, confirmation of: 1. Guardian notification 2. Incident report completion Eliada has a new Medical Director that joined the agency on December 20, 2018. He is working with the PQI Director and Eliada's nurse manager to develop a procedure for drug testing/urine screens. The new procedure will be implemented by the end of January.	1/31/2019

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teach coping, pro-social, decision making, problem solving and anger management skills. To provide behavioral and crisis management interventions. To monitor throughout sleeping hours. To facilitate therapeutic leave. To evaluate and monitor the efficacy and side effects of medications as well as inform consumer and guardian. One staff will provide transportation off campus as safety allows".
-No goals to address the substance abuse.
-No strategies or interventions to address the substance abuse, elopements, or behaviors and non-compliance around therapeutic leave.
-It was unclear if supervision was provided during after school activities by the facility, a therapist or the guardian.

Review on 11/7/18 of incident reports for Client #1 from 10/1/18-11/7/18 revealed:
-On 10/2/18 " ...Staff transitioned [Client #1] to school at 3pm for an after school program. Staff received a phone call around 8:45pm from [Client #1's] mother, asked to speak to her. Staff gathered from mom that [Client #1] told mom a friend would drive her back to [facility] due to mom being late. [Client #1] did not arrive back to campus ...staff was filing a missing person's report ...student did not return to campus ..."
-On 11/5/18 " ...Staff noticed the smell of marijuana coming from the bathroom. Staff checked the bathroom after [Client #1] had finished using it. Staff found a small bag with tobacco and marijuana and lighter. Staff checked in with [Client #1] to tell her what was going to happen but she was already under the influence of the drug and would not focus on staff ..."
-On 11/6/18 at 8:00PM " ...[Client #1] told staff that she was going to run but didn't want to run ... [Client #1] told staff that she had marijuana on her person and wanted to get rid of it so she

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V 112	Continued From page 4 would not get in any trouble ...[Client #1] decided to run with the marijuana on her person ...[Client #1] returned later in the evening with the police ..." Review on 11/15/18 of daily service notes for Client #1 revealed: -On 8/28/18 " ...[Client #1] was on therapeutic leave ...Staff were alerted that [Client #1] ran away during her therapeutic leave ..." -On 9/4/18 " ...Staff noted [Client #1] went on her off-campus pass with her mother at 3:20pm. Staff received a phone-call from [Client #1] stating that her mother wished her to come back the following day ...Staff observed [Client #1] to remain off campus on an unapproved pass ..." -On 9/5/18 " ...[Client #1] stated she may not pass drug test because she had used marijuana in previous visit and may fail again. Staff asked [Client #1] if she had used substance on pass and [Client #1] did not answer ..." -On 9/13/18 " ...off campus ...[Client #1] did not come back from pass last night (9/12/18)" -On 9/14/18 " ...Staff noted [Client #1] stating she had a pass today ...upon returning to the cottage and hearing her pass was not approved [Client #1] entered a negative space ...[Client #1] left with her without [facility] approval ..." -On 9/15/18 " ...off campus ..." -On 9/16/18 " ...returned to cottage at 7:50pm ..." -On 9/20/18 " ...[Client #1] refused to return to [facility] when staff went to pick her up. [Client #1] remained AWOL ...Staff noticed [Client #1] return to the cottage at 10:13pm ...[Client #1] refused to take her drug test ...[Client #1] took her drug test..." -On 9/27/18 " ...[Client #1] returned to cottage with her mother around 2:30 ...Staff confronted [Client #1] about leaving again with her mother for an unwarranted pass. Staff directed [Client #1] to	V 112		

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V 112	Continued From page 5 take a drug test since she ran away from school and was suspended. Staff provided opportunity for [Client #1] to stay with cottage instead of leaving. Staff observed [Client #1] leave with her mother ...[Client #1] returned to the cottage around 8:30 ..." -On 10/2/18 "(second shift note) ...Staff transitioned [Client #1] to [local high school] to pick up peers. Staff walked [Client #1] down to an after school club she had approval for. Staff noted [Client #1] was going to staff off campus until 9pm. Staff noted [Client #1] did not return ... (third shift note) ...[Client #1] remained AWOL for the duration of this shift ..." -On 10/23/18 " ...[Client #1] was in after school activities for the majority of the shift. Staff noted [Client #1] returning at 8:05pm ...Staff noted that [Client #1] appeared to be under the influence of a substance ..." -On 11/1/18 " ...Staff noted [Client #1] ran from school and did not return to the cottage ..." -On 11/2/18-11/4/18 " ...AWOL/runaway ..." -On 11/5/18 " ...Staff observed that the bathroom smelled of smoke, possibly marijuana, after [Client #1] used it. Staff went into student bathroom after [Client #1] had vacated and discovered a lighter and a bag with something in it. Staff contacted the PM (program manager) on duty. Staff continually kept [Client #1] in eyesight unless she was in the bathroom or sleeping ..." -On 11/6/18 " ...[Client #1] told staff that she was had marijuana on her and that she wanted to get rid of it so she didn't get in trouble. [Client #1] told staff she was tempted to run so she could get rid of the marijuana, but that she didn't want to run and was feeling sad and frustrated. [Client #1] ran and returned to the cottage later in the evening ..." Review on 11/9/18 of the Nursing Report from	V 112		

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V 112	Continued From page 6 8/16/18-11/6/18 for Client #1 revealed: -"8/16/18: [Client #1] was admitted to [facility] today. She was not observed in the admissions office due to running off campus upon arrival to [facility] ...Mother and client report that she uses marijuana, Xanax and alcohol frequently. [Client #1] reports that she has used cocaine about 5 times total. [Client #1] reports having used alcohol, Xanax and cannabis all last night ...rapid UDS (urine drug screen) being positive for Benzodiazapine and THC (marijuana) ..." -"8/28/18: Patient was not on campus for medical appointment" (Missed due to elopement while on therapeutic leave). -"8/29/18: ...Positive for THC ..." -"9/5/18: Student arrives back to the cottage after unexpected TL (therapeutic leave) last night ...She did not want to give her urine sample ..." -"9/19/18: Student's Random Rapid UDS continues to be the same as it was (+ for THC), however, the green mark for temperature did not register ..." -"9/20/18: The student returned to Eliada campus a little after 10 PM ...The student seemed slightly out of it, seemed to be slightly slurring her words and talking slowly. She also seemed to struggling a little to keep her eyes open. She did not smell of alcohol or smoke. I attempted to have a conversation with the student about where she had been, who she had been with, what she had been doing, etc. but she would barely engage. She told me that she had not been with her mom the whole time, was with friends, and was doing "stuff" ...At this point she decided that she was not going to give urine for a rapid UDS ..." (Note did not fully print but the Nurse confirmed that UDS was collected and was positive for THC and that urine seemed diluted). -"9/27/18: Rapid UDS done on student. THC positive ...Temperature gage did not change	V 112		

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V 112	Continued From page 7 colors, although, urine did not look watered down. Student reported getting suspended today d/t (due to) drinking a small amount of a peers alcoholic drink at school. Student did not appear intoxicated ..." -"10/1/18 Physically unable to take ...no cups available" -"10/3/18: Rapid UDS is positive for THC (collected after student ran 10/2/18) ..." -"10/4/18: ...THC was positive ..." -"10/6/18: ...UDS is still showing positive result for THC ..." -"10/10/18: Student did not return to campus until almost 2 am ...Student appeared to possibly be under the influence of some type of substance. Student denied use ...Rapid alcohol swab was negative. Student reported no need to urinate, therefore, rapid UDS was not completed ..." -"10/16/18: ...UDS was completed ...positive for THC ..." -"10/20/18: Rapid UDS positive for THC ..." -"10/23/18: [Client #1] was suppose to return to campus at 8pm on 10/22 but instead didn't return to campus until 10/23 at 12:30am. She appeared to be under the influence of THC and a rapid UDS revealed positive result for THC ..." -"10/24/18: On 10/19/18 student reported to the RN (registered nurse) that she had been sexually active and that she wanted to get on some sort of BC (birth control) ..." -"11/6/18: Urine drug screen positive for THC ..." Review on 11/9/18 of the Therapy notes for Client #1 from 8/17/18-10/26/18 revealed: -On 8/29/18 the Individual Therapy note indicated " ...Therapist engaged [Client #1] in conversation to better understand why [Client #1] ran on a pass ...Therapist provided [Client #1] with psychoeducation on what will be expected pf her in future passes. Therapist began to process and	V 112		

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V 112	Continued From page 8 develop skills to assist in not running away from problems ..." -On 9/6/18 the Individual Therapy note indicated " ...Therapist utilized motivational interviewing to gage what stage of change [Client #1] was in for her substance use and other behaviors. Therapist provided [Client #1] with psychoeducation based on those levels of change ...[Client #1] showed responsibility in recognize things she can do to reduce her behaviors while at home ...Therapist will meet with [Client #1] to discuss skills that she can utilize at home ..." -On 9/28/18 the Individual Therapy note indicated " ...Therapist attempted to check in with [Client #1] as [Client #1] has been on unapproved passes or has been on the run on multiple occasions when therapy was going to happen ..." -On 10/25/18 the Individual Therapy note indicated " ...Therapist continued to engage [Client #1] in conversation about her motivation to look into other things in her life that are impacting her, including her behaviors in school and on passes ...[Client #1] was smiling when the conversation about her behavior about passes and school was discussed and possible consequences ..." -Individual therapy sessions were conducted additionally on 8/17/18, 8/21/18, 10/2/18, 10/10/18, 10/12/18, 10/17/18, 10/22/18, and 10/26/18. These sessions indicated introductions, the use of Equine therapy, healthy relationships, being healthy, and options to destructive thinking, and issues going on in her life but failed to address the continued substance use while in level III treatment. -No therapy documented between 9/6/18 and 9/28/18. -No family therapy documented. -No group therapy or individual therapy for	V 112		

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V 112	Continued From page 9 substance abuse documented. Review on 11/9/18 of the Multidisciplinary Staffing documentation for Client #1 revealed: -On 9/13/18 " ...[Client #1] has expressed a desire to begin family therapy as she recognizes her issues and behaviors arise mainly at home ... [Client #1] has utilized drugs on multiple occasions while on pass with mother ...Family therapy is scheduled to begin next week. [Client #1] will also attend substance use group therapy ..." No recommendations documented. -On 10/11/18 " ...she attends a court ordered weekly group and frequently takes advantage of this time to either leave her mother's supervision or to convince her mother to return her late to Eliada. She has shown an increase in behaviors while at school (suspended for drinking alcohol on school grounds or eloping from school grounds) ...she continues to test positive for THC and other drugs ...Focus of Treatment Recommendations: Engagement in Eliada expectations ..." Review on 11/9/18 of the Child and Family Team (CFT) Meeting Minutes for Client #1 revealed: -CFT conducted on 9/13/18. Documentation indicated a review of the Therapeutic Leave/Visitation policy. No discussion of non-compliance around therapeutic leave or substance use. This documentation indicated Family therapy to begin "next week". Parent, School Representatives and Court Counselor present. -CFT conducted on 10/11/18. Documentation indicated " ...Central issue ...[Client #1] is not returning on time from family passes, not at the van when staff goes to pick her up, and drug tests are all positive for marijuana ...The supervisors would like for her to be placed in day treatment.	V 112		

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Day treatment was explained ..." Parent present by phone.

No documentation available of any other communication with the local high school or the parent of Client #1.

Interview on 11/8/18 with Client #1 revealed:
-She had been at the facility for 3 months.
-She had been pulled out of school and was now in the facility academy. She was not happy about that because she wanted to graduate with her senior class.
-She had urine drug screens done and they had been positive. She indicated that staff talked to her about the positive screens and that is why she can't go on passes for a while.
-She met with her therapist once per week. She had equine therapy on Fridays.
-She said recently staff smelled something in the bathroom and the police came. She also stated she ran away once and was gone a couple of hours and came back on her own. When she got back the police came.

Client #2:

Record review on 11/7/18 and 11/8/18 for Client #2 revealed:
-Admitted on 8/13/18 with diagnoses of Unspecified Depressive Disorder, Other Specified Anxiety Disorder, Cannabis Use Disorder Severe, Sedative, Hypnotic or Anxiolytic Use Disorder Severe, Stimulant Use Disorder Severe and Alcohol Use Disorder Moderate.
-Assessment dated 7/6/18 indicated " ...Presenting Problem ...history of ...substance use, overdose, and relapses ...Adverse Childhood Experiences: ...household substance use ...DSS removed [Client #2] from home due to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 11 safety issues and family knowing about substance use/not having safety plans in the home around this ...Problems at School: ...Truancy due to substance use ...[Client #2] has experimented with many drugs, and states many times using drugs in combination with other drugs or alcohol ...Any negative behaviors in[Client #2's] history appears to be linked to Substance Use ...If he is accepted to other Level 3 Residential programs it is important to evaluate whether program will fit his needs regarding Substance Use Treatment ...If it is not included in the program, he can benefit from SAIOP (Substance Abuse Intensive Outpatient Program) in combination with Level 3 ...Experience Blackouts and Overdoses ..." -Assessment dated 7/6/18 indicated Substance Use History as "Alcohol ...3 x week ...Marijuana ...multiple times per day ...Cocaine ...3-9 times in his life ...Opiates ...Oxy (OxyContin) and Percocet up to 1 x per week ...Prescription pills ...end of 2017 around 4-5 x week ...Hallucinogens ...increased to daily in early 2018. LSD once every 2 months ..." Review on 11/8/18 of the Treatment Plan dated 8/1/18 (with updates on 9/17/18, 10/1/18 and 10/15/18) for Client #2 revealed: -Goals included " ...[Client #2] will demonstrate an improvement in symptoms Cannabis Use Disorder as evidenced by increased honesty about Cannabis use, elimination of Cannabis use, and decrease involvement with substance using friends ...[Client #2] will demonstrate an improvement in symptoms of Sedative, Hypnotic or Anxiolytic Use Disorder as evidenced by increased honesty about Sedative use, and elimination of sedative use ...[Client #2] will demonstrate an improvement in symptoms of Stimulant Use Disorder as evidenced by	V 112		

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increased honesty about Stimulant Use and elimination of Stimulant use...[Client #2] will demonstrate an improvement in symptoms of Alcohol Use Disorder as evidenced by increased honesty about Alcohol Use and elimination of Alcohol use ..."
-Strategies/Interventions for all goals were "To teach coping, pro-social, decision making, problem solving and anger management skills. To provide behavioral and crisis management interventions. To monitor throughout sleeping hours. To facilitate therapeutic leave. One staff will provide transportation off campus as safety allows ...Medication Management: To evaluate and monitor the efficacy and side effects of medications as well as inform consumer and guardian ..."
-Treatment plan failed to specify specific interventions used to address the substance use, elopements or school truancy.

Review on 11/7/18 of incident reports for Client #2 from 10/1/18-11/7/18 revealed:
-On 11/6/18 at 5:00PM " ...Staff noticed the smell of marijuana coming from the restroom. Staff went in the restroom after [Client #2] was done and did not find anything. [Client #2] told staff that he had smoked and that he had more marijuana on his person ...[Client #2] told staff that he acquired the marijuana from a peer in the cottage ..."
-On 11/13/18 " ...[Client #2] came out of his room to use the restroom. [Client #2] went back to his room after 2 minutes ...Staff did a scheduled 5 min check on [Client #2]. Staff noted [Client #2] had left his room through his bedroom window ...Staff went outside to check if they could see [Client #2] ...11/14/18-[Client #2] returned to the cottage on his own around 3:45pm, coming to the cottage door trying to get in ...[Client #2] told staff

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he slept in an abandoned mansion and was having a great day ..."

Review on 11/19/18 of daily service notes for Client #2 revealed:
-Service note for second shift on 9/24/18 not documented.
-Third shift service note for 9/24/18 indicated "Staff observed [Client #2] to be off campus when 3rd shift stepped on the floor. Staff observed [Client #2] arrive back to the cottage by [local law enforcement] and staff around 10:37 pm ...provided nursing his urine sample ...Staff observed [Client #2's] demeanor to be out of the ordinary and suspected he had used some kind of substance while away from campus ...Staff observed [Client #2] talk with staff about where he had run to [local grocery store] and taken an over the counter drug as to which he referred to as triple c's. Staff listened as [Client #2] told staff the "he felt great and that he was so f***ed up" and then laughed about it ...observing [Client #2] as he out of nowhere vomited into the sink ... continuing to vomit ...Staff called nursing ...he then told staff he had taken 39 of them ...[Client #2] spoke up saying oh well if you overdose you overdose it happens shouldn't take so many I guess and laughed about it ..."
-On 10/22/18 " ...Staff went to [local high school] to pick up [Client #2] from police custody ...Staff checked in with [Client #2] about what substances he took and the quantity of these substances ...[Client #2] was in an intoxicated state when staff picked him up from school ... [Client #2] told staff he had drunk alcohol and how much he drank ...staff came to take him to the hospital ..."
-On 11/3/18 " ...Staff redirected [Client #2] when he became hyper focused on not being able to go

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off campus due to the level 3 vehicles being occupied ...Staff redirected [Client #2] when he threatened to leave campus if he did not get to go off campus ...Staff disengaged from [Client #2] when he repeatedly made suicidal ideations about dying from an overdose. Staff checked in with [Client #2] about going off campus and provided him with expectations ...staff observed [Client #2] walk away without staff permission ... [Client #2] continued to walk off campus ...Staff redirected [Client #2] when he tried to go to [local pharmacy] and stated he was going to steal an energy drink or go to [local grocery store] to steal coffee ...staff provided increased checks on [Client #2] upon returning to the cottage..."

Review on 11/9/18 of the Nursing Report from 8/15/18-11/4/18 for Client #2 revealed:
-"9/5/18: Rapid UDS appears to be negative, however the line double line for THC is faint on the bottom (possibly inconclusive) ..."
-UDS testing on 9/10/18, 9/19/18, and 9/23/18 were negative for illicit substances.
-"9/24/18: [Client #2] was brought back to campus at 11pm by Cottage supervisor after running off campus at around 5pm. [Client #2] appeared to be under the influence when he reentered the cottage. Nursing performed a rapid UDS sample but was not a valid sample. Nursing performed a saliva alcohol swap that showed a very faint line showing a possible indication of alcohol consumption ...nursing was called due to him throwing up and admitting to consuming a large amount of the substance, triple c. He stated he consumed 39 of these pills ...recommendation was made to take him to be evaluated at the emergency department."
-Urine drug screens were documented as administered on 9/29/18, 10/5/18 and 10/11/18 but no results were documented by the nurses.

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V 112	Continued From page 15 -"10/17/18 negative for all substances." -"10/22/18: Student was brought home from school today after skipping and reportedly going to [local grocery store] and buying ETOH (alcohol) (40oz he says) and drinking it all. He did appear intoxicated. He get up to go to the bathroom and after walking through the door of the bathroom fell on the floor. Upon checking on him, he immediately go up and reported that he got dizzy and fell. He did not having observable injuries from the fall. He took a while in the bathroom but did bring a Rapid UDS specimen to this RN (registered nurse). The temperature gage did not read accurately (by turning green). Therefore, was inconclusive. His ETOH swab was negative for ETOH=or greater than 0.02% ETOH. [Therapist], [Residential Services Director] and this RN felt it was in his best interest to go to the ED (emergency department) for safety purposes and to determine if he was on any other illicit drugs ..." -"10/23/18: [Client #2] returned from the Emergency department ...diagnosed him with acute alcohol intoxication and no further recommendations. His blood work revealed that his blood alcohol level was 0.059 ..." -A urine drug screen was documented as administered on 10/29/18 but indicated "cup left in cottage. Student aware". A result was not documented. Review on 11/`15/18 of the hospital records for Client #2 revealed: -Emergency room report dated 9/25/18 ...Chief Complaint: Substance Misuse/Intoxication ...Diagnosis: Acetaminophen overdose, Intentional drug overdose ...Pt (patient) did not attempt suicide and this was an attempt to get high. Pt denies SI (suicidal ideation) ..." -Emergency room report dated 10/22/18	V 112		

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V 112	Continued From page 16 ...Diagnosis: Acute alcohol intoxication ..." Review on 11/9/18 of the Therapy notes for Client #2 from 8/15/18-11/5/18 revealed: -Individual therapy session on 9/28/18 indicated " ...Therapist engaged [Client #2] in conversation to best understand how he bounced back from his incident Monday night (overdose) ...Therapist assessed [Client #2's] level of motivation to move forward and utilize skills he is working on such as asking for help and utilizing his coping skills ..." -Individual therapy session on 10/22/18 indicated " ...Therapist engaged [Client #2] in conversation eventhough he was intoxicated from alcohol. Therapist assessed [Client #2's] level of judgement and understanding of potential consequences ...[Client #2] discussed making a poor decision ...expressed regret for his behaviors and understood potential consequences ..." -Additional individual therapy sessions were conducted on 8/15/18, 8/21/18, 8/29/18, 9/4/18, 9/15/18, 9/18/18, 9/20/18, 10/3/18, 10/9/18, 10/15/18, 10/18/18, 10/24/18, 10/29/18, and 11/5/18. -These therapy sessions addressed use of coping skills when wanting to engage in risky behavior, how to ask for help, effective communication, how to express emotions, smoking cigarettes on campus, how to address anger, behavior control and the implementation of Equine Therapy. These sessions did not indicate that substance use was addressed as part of his treatment. -Two family therapy sessions documented on 9/24/18 and 10/1/18. -No group therapy for substance abuse documented. Review on 11/9/18 of the Multidisciplinary Staffing	V 112		

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V 112	Continued From page 17 documentation for Client #2 revealed: -On 9/13/18 " ...[Client #2's] UDS have been negative.**Important to note that his drugs of choice historically have been over the counter and will not show up on a drug screen ...[Client #2] has shown resistance to the level III program ...He has attempted to have conversations with his peers about how to fool a drug test and which substances they could use that would leave their system quickly ...He attends public school at [local high school] and so far there have been no reported issues. [Client #2] informed staff that if they do a weekly random drug test, it just means that the next day the students are clear to use substances until the next week ...[Client #2] will begin engaging in a substance use group next week ..." -On 10/11/18 " ...[Client #2] has continued to show symptoms of substance use ...Academic Update: ...no disciplinary actions to report ..." Review on 11/9/18 of the Child and Family Team (CFT) Meeting Minutes for Client #2 revealed: -CFT conducted on 9/17/18. This documentation indicated " ...[Client #2] begins substance use group therapy this week ..." -CFT conducted on 10/1/18. This documentation indicated " ...emergency CFT was called by [Client #2's] team due to his behavior a week prior in which he ran away from the cottage and overdosed ..." Absences were indicated in several school classes and the report indicated " ...Clinician will follow up for absence dates ...Clinician will begin anger management therapy ..." -CFT conducted on 10/15/18. This documentation indicated " ...[Client #2] actively engages in substance use group therapy once every other week currently ...Clinician discussed the possibilities if a pattern of marijuana use	V 112		

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V 112	Continued From page 18 continues, which could include day leaving public school and going to day treatment. Clinician discussed substance use treatment not beingone the table for marijuana. Clinician further discussed is use is a problem, a higher level of care is possible ...Educational/Vocational: ...There are a couple unexplained absences and tardies ..." -No school representatives participated in any of the CFT meetings. Interview attempted on 11/8/18 but Client #2 refused. There was no policy for Urine Drug Screening available for review. Interview on 11/9/18 with the Lead Registered Nurse (RN) revealed: -All students that attended public school were tested weekly for drugs through a urine drug screen. -Students also had a urine drug screen conducted following any visit off campus. -Nurses conducted the urine drug screening. -Client #1 consistently tested positive for marijuana. -On 10/1/18 Client #1 did not receive a UDS because the facility had run out of cups. She indicated that the testing cups were either on back order or were not delivered timely by the pharmacy. -When Client #2 had an oral alcohol swab completed on 10/22/18, the alcohol did not register on their swab. She indicated that they had not used swabs a lot and that they needed more sensitive swabs for alcohol testing. -She stated that when the temperature gage did not register green something was either wrong with the temperature gage or the urine had been	V 112		

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V 112	Continued From page 19 diluted. -She indicated that on the dates Client #2 had no result documented for his UDS either the test occurred and it was not charted or the test actually did not occur. Her assumption was that Client #2 did not have the test. Interview on 11/8/18 with Residential Counselor #1 revealed: -He worked second shift. -On 11/5/18 Client #1 was picked up from school by the Therapist and Cottage Supervisor. Both the Therapist and Supervisor suspected that Client #1 had drugs on her person but that information was not communicated to him. He indicated that he "had no idea what was going on" and he "was not in the loop". He indicated that he would have kept a closer eye on Client #1. Client #1 asked to take a shower and the staff smelled marijuana while she was in the shower. After she was finished with her shower the bathroom was searched and staff found a bag that contained a lighter and a "blunt". They notified the Cottage Supervisor and the local police department. -He stated that Client #1 was observed to have red eyes, decreased focus, decreased communication and she appeared to "space out". He indicated that he had seen her "high" before. -He stated that they determined that Client #1 had offered the drugs to Client #3 but they were able to locate the drugs before Client #3 had used any. -On 11/6/18 Client #2 wanted to take a shower after school which he indicated was unusual. Staff again smelled marijuana in the bathroom and searched the bathroom but found nothing. He stated that Client #2 also appeared impaired. Client #2 admitted to smoking marijuana in the bathroom and informed staff that he had hidden the marijuana in his crotch. He stated that they attempted multiple times to get Client #2 to turn	V 112		

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over the marijuana.
-Additionally, on 11/6/18, Client #1 said she had marijuana but refused to give it to staff after multiple attempts to convince her to do so. Shortly thereafter, Client #1 eloped and later returned to the facility impaired. Local law enforcement had been contacted when Client #1 ran out of sight and were in the facility when Client #1 returned. A body search was conducted on Client #1 by law enforcement. Urine drug screens were conducted for Client #1 and Client #2 and both tested positive for marijuana.
-He indicated a team meeting was conducted on 11/7/18 to discuss steps to take with Client #1 and Client #2.
-Every time a client returned from being off campus searches were conducted.
-The searches involved emptying out pockets, shaking out clothing, underwear bands and bra bands. Shoes were also removed and checked.

Interviews on 11/7/18, 11/13/18 and 11/15/18 with Residential Counselor #2 revealed:
-He was a Night Residential Counselor.
-He stated that the current census was "the worst group right now for sneaking things in".
-Client #1 had run 6 or 7 times. He stated she would leave school with "her boyfriend" and return to the cottage "high" at 1:00AM. He stated she "was high" every time she returned to the cottage and tested positive for marijuana consistently. Furthermore, he stated she was off campus every week and was supposed to be with her mom but "they knew that wasn't happening". Client #1 was going on passes but some days would not return to the cottage.
-The incidents on 11/5/18 and 11/6/18 was the first time that drugs were coming into the cottage.
-Every time Client #1 returned to the cottage on his shift he observed her to be lethargic, have

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slow reactions, and her eyes were glazed over.
-He indicated that her behavior "has been allowed to continue" and she was "continued to let go on pass".
-The incident on 11/6/18 for Client #2 was not the first time he was involved in drug use. He stated that Client #2 had eloped on a prior date and used drugs and also eloped from school on one occasion got drunk.
-Most recently, Client #2, who wore an ankle bracelet, cut it off his ankle and eloped again from his bedroom window in the cottage. Client #2 was gone overnight and returned to campus the following day. Client #2 reported that he had stayed in an abandoned building overnight. Probation officers came on site upon Client #2's return and escorted him to the local jail.

Interview on 11/7/18 with Residential Counselor #3 revealed:
-She worked second shift.
-On "at least" 2 occasions when she went to pick up Client #1 from school she was not there. She indicated that she went to the office and her name was called over the loud speaker. The attendance record was checked and Client #1 had "skipped class". She immediately called the Cottage Supervisor and Therapist. She stated that "sometimes" a missing persons report was completed.
-"She (Client #1) usually shows up." She indicated that sometimes Client #1 showed up to the facility later the same night. Client #1 was returned to campus by someone who was not her parent. She stated that one time Client #1 was spotted at a gas station.
-She indicated that every time Client #1 returned to the cottage she was "on drugs".
-She stated that there had been threats to pull Client #1 out of public school which finally

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occurred on 11/5/18. She indicated that the therapeutic leave overnight visits stopped "2 weeks ago".

Interview on 11/7/18 with Residential Counselor #4 revealed:
-Whenever clients returned to the cottage after school or therapeutic leave a search was conducted.
-The process involved use of a wand on the client, search of any bags, emptying pockets, shaking out of clothing and rim of socks, and shoe removal.
-Documentation of the search was included in their service notes.
-They did not pat down the clients. He indicated that if they observed "a bulge" they would ask the client to show them.
-He had interaction with Client #1 after the incident on 11/6/18. Client #1 asked to check in with him. She informed him that she wanted to run and admitted that she had marijuana on her person. He stated he talked to her for an hour and tried to convince her to turn over the drugs and the potential outcomes of what could happen. He indicated that after a while he returned back into the cottage (they had been on the front porch) but still maintained eyesight through the open door. She then eloped, he followed and eventually lost eyesight of her at which time he contacted the authorities.

Interviews on 11/8/18 and 11/19/18 with the Cottage Supervisor revealed:
-Client #1 typically eloped from school or while on pass.
-Most recently on 11/1/18 she gave the School Resource Officer a fake name of someone that was to pick her up from school. She was picked up from school by someone no one knew but they

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V 112	Continued From page 23 suspected the person was a former boyfriend. She was gone until she returned to school on Monday 11/5/18. She was returned to campus and admitted into their day treatment program. On that date she was removed from the local high school. -There were times that staff would pick up from school and she was gone. -She indicated that the teachers at the local high school did not take attendance. She never received a call that Client #1 or Client #2 were not in class. -At the first Child and Family Team meeting transportation to and from the therapy group (Love Notes, therapy group about relationships that had been court ordered) and after school activities had been arranged with Client #1's mother. On 10/2/18 Client #1's mother indicated she had a problem with her vehicle but did not communicate with the facility. -When on therapeutic leave with her mother sometimes she would return and sometimes not. -Therapeutic leave passes stopped in mid-October. Interviews on 11/8/18 and 11/20/18 with the Therapist for Client #1 and Client #2 revealed: -She was an LCAS-A (Licensed Clinical Addiction Specialist) and LCSW (Licensed Clinical Social Worker). -She conducted 1 hour therapy per week with each client. -She conducted 2 hours of family per month and 1 Child and Family Team meeting per month. -She had not added any goals to Client #2's treatment plan to address elopements. -She had not included any goals or strategies to address substance abuse for Client #1 because Client #1 had not been diagnosed with a substance abuse disorder. She felt that the goals	V 112		

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V 112	Continued From page 24 in her plan would be applicable to that issue. -Client #1 would elope primarily while on therapeutic leave. When with her mother Client #1 would end up with friends and indicated that her mother did not know how to handle the issue. -Client #1 was on the run at times when her therapy was scheduled so there were weeks when she may not have had a session. -Therapeutic leave was ended for Client #1 around approximately 10/25/18. -She stated that the facility was not informed when the clients were not in class. She indicated that just recently they began to call the school and verify if their clients were in class. -There had been instances when Client #1 would refuse to get in the van when staff picked up after school. Client #1 would go back into school and then they were unable to locate her and would file a missing persons report. -Client #1 was removed from the school and admitted to their day treatment program on 11/5/18. -Client #1 had not passed one urine drug screen. -There had been "many conversations" with Client #1 about removing her from public school if the running and drug use continued. -She indicated that she "had talked to mom a lot about what was going on during passes". -She stated that ideally she talked to guardians once per week but that varied based on the needs of the student. -She stated that she had one family therapy session that had been scheduled for Client #1 and Client #1's mother did not show up. She attempted to reschedule but they were unable to work out a time. -She had conducted 3 or 4 group therapy sessions for substance abuse but had been told not to document those sessions because there "was no code". She stated it was frustrating to try	V 112		

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V 112	Continued From page 25 and arrange group sessions because Client #1 would be missing. She also indicated it "became a staffing issue". -The topics she covered in the group sessions for substance abuse were "recovery mindset, characteristics of a substance abuse disorder and relationships". -Client #2 had been removed from the local public high school following his last elopement (on 11/9/18). -She was unaware of the attendance problems for Client #2 at the local public high school. She stated that she found out on his last day that his grades and attendance had declined significantly. She indicated that she had called the school daily for the last two weeks and was told he was in class. She stated that when she requested his attendance record his attendance was inconsistent with what she had been told. -Her primary avenue for communication with the school was the CFT (Child and Family Team) meetings. Interview on 11/9/18 with the Clinical Director revealed: -Individual therapy was conducted weekly and should address both mental health issues as well as substance abuse issues. -Family therapy was conducted twice monthly. -The Group therapy was currently being "beefed up". The Therapist had started to conduct some groups but had stopped. The Licensee had just received a new model curriculum to use for group therapy but the Therapist would need to be trained for proper implementation. -Client #1 did not have a substance abuse diagnosis and therefore no goals or strategies had been included in her treatment plan. She stated that goals for the PCP's were based on each diagnoses that were indicated.	V 112		

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V 112	Continued From page 26 -Diagnostic changes would have been addressed in the multi-disciplinary team meetings and then the treatment plan would be updated. This should have occurred for Client #1 due to her level of substance abuse but it did not. -The Licensee was currently in the process of changing the entire person centered plan process to ensure interventions were more individualized. -The interventions in the treatment plans for Client #1 and Client #2 were not specific to substance abuse. Interviews on 11/15/18 and 11/16/18 with the local high school Resource Officer revealed: -He was working on 11/1/18 when Client #1 eloped from school. She jumped into the car of a friend (non-student) and left school. He had contact with Eliada on this date and they asked him to file a missing persons report. Client #1 returned to school a few days later. -He stated that Client #2 "would run off just about daily from school". He further indicated that Client #2 was caught intoxicated at school and was "busted smoking in the woods". He said that Client #2 would leave school and go to the local grocery store and obtain alcohol. -His contact with Eliada was only when the problem became a law enforcement issue. He had no conversations with Eliada about the behaviors of Client #1 or Client #2. Attempts were made on 11/15/18, 11/16/18 and twice on 11/19/18 to contact the School Social Worker. All attempts were unsuccessful. Interview on 11/20/18 with the Residential Services Director revealed: -Family therapy was to occur at a minimum of twice monthly. It was designed around the needs of the child and family and what worked best for	V 112		

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V 112	Continued From page 27	V 112		

the family.
-Client #1's mother did not speak English and all communication went through an interpreter. Staff would report issues to the interpreter who then would communicate with the mother. Her mother did not always participate in meetings.
-He was not aware of how much family therapy was accomplished with Client #1 and her mother.
-He indicated that they struggled with how to engage Client #1's mother and work with Juvenile Justice who wanted Client #1 to remain in public school. He stated that in meetings they had tried to get through to Client #1 but it finally got to the point that she wasn't safe and the decision was made to pull her out of public high school.
-He was not sure if the Group therapy for Substance Abuse ever got off the ground. There was no model for substance abuse therapy that had been utilized.
-There was no policy in place for the urine drug screening. Staff were not clear on the procedures for urine drug screening. He did not know how the procedures used by the nursing staff had been established.
-"We have work to do on urine drug screening."
-Treatment plans should address the substance abuse issues.
-There had been ongoing problems working with the local high school and communication with the Guidance Counselor had been problematic.

This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (293) for a Type A1 rule violation and must be corrected within 23 days.

V 293	27G .1701 Residential Tx. Child/Adol - Scope	V 293		

10A NCAC 27G .1701 SCOPE
(a) A residential treatment staff secure facility for

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V 293	Continued From page 28 children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and	V 293		

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V 293	Continued From page 29 agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record review and interview the facility failed to design services that would minimize the occurrence of behaviors, ensure safety and deescalate out of control behaviors and failed to coordinate with other individuals and agencies within the child's system of care affecting 2 of 3 current clients (#1, #2) and 1 of 1 former clients. The findings are: Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review and interviews the facility failed to develop and implement goals and strategies to address the behaviors effecting 2 of 3 current clients (#1, #2) and 1 of 1 former clients. Review on 11/9/18 and 11/20/18 of the Plan of Protection signed and dated by the Director of Performance/Quality Improvement on 11/9/18 and 11/20/18 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk? "-A full cottage safety sweep and room search will be completed on Saturday afternoon after 2pm. Students will be notified immediately prior to the	V 293		

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V 293	Continued From page 30 search and will be present. The search will be facilitated by Eliada's Crisis Manager with the full-time Green Residential Counselors on shift. The students will be supported during this process by Eliada's Clinical Director. This will ensure the environment is free from substances and any other prohibited items that might jeopardize the safety of the students. -Room checks will be increased to every 5 minutes when students are in their respective bedrooms. This will be conducted during both waking and sleeping hours for all students. The room checks will be documented and maintained in the cottage safety binder and reviewed by the Cottage Supervisor daily. -The students in Green Cottage will have no off-campus activities until further notice. -The staff in Green Cottage will maintain structured activity blocks daily to keep the students engaged as a group. This will be clearly documented in the progress notes for each student on each shift. -Green Residential Counselors will facilitate one psycho-educational group with the students daily, beginning on Saturday, 11/10/18. Staff have been provided with manualized group therapy workbooks and will address topics related to self-esteem, positive decision-making, managing emotions, resisting peer influences and recovery principles. The daily group topic and therapeutic activities will be detailed in each students progress note. -One student, who has not engaged in substance use nor secretive behaviors will maintain a therapeutic leave visit this weekend, in support and preparation for the upcoming discharge and transition to the family home. -Eliada's Residential Director and Green's Clinical Supervisor (both of whom have clinical expertise in substance abuse treatment will provide a	V 293		

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V 293	Continued From page 31 required training for ALL Eliada Level III Residential Treatment Staff on Wednesday, November 14 from 9am-11am. This training will address Adolescent Substance Use, Prevention and Intervention Strategies. -The Clinical Supervisor will follow up with the identified students and their affiliated Child and Family Team to update diagnosis and PCPs (person centered plans) to reflect the need for interventions and treatment related to substance use by Thursday, 11/15/18. -Alternate school arrangements have been secured for the two students with recent significant drug use. Education will be provided on Eliada's campus and will eliminate the opportunity for the either to secure substances. A meeting with local high school personnel was conducted with Eliada staff on 11/9/18 to finalize these arrangements for the second student. -**All (4) students in Green Cottage will be reviewed through the process of a Clinical Case Review, to be completed by Wednesday, 11/28/19. Eliada has revised the Clinical Case Review process and documentation, which now has an embedded Individual Crisis Management Plan/Strategies for the Comprehensive Crisis Plan. This plan includes student-specific details for: i. Pre-Crisis: What is the student's baseline? What does it look like when the student is doing well? ii. Triggering: (events and early signs that student is not doing well) iii. Prevention and Early Intervention Strategies: (Engagement and calming strategies: what works well, doesn't work well) iv. Escalation and Outburst: (strategies for crisis response and stabilization) v. Recovery: (specific needs or supports after crisis)"	V 293		

Division of Health Service Regulation

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V 293	Continued From page 32 Describe your plans to make sure the above happens: "-The cottage search and environmental safety sweep will be monitored by the Crisis Manager. The search will be documented as an incident report and will have the accompany search and seizure documentation. The guardians will be notified of this event and any findings. -The Supervisor on site will review the Room Check logs on Sunday evening for Saturday and Sunday. The Cottage Supervisor will review the Room Check Logs daily beginning on Monday, 11/12/18, to ensure that increased room checks are completed and documented. The Residential Director will be notified of any deficiencies or student non-compliance. -The Supervisor on Site will review all shift notes for the students in Green Cottage on Sunday evening for 11/10/18-11/11/18. The Residential Administrative Assistant will review all shift notes for the students in Green Cottage daily beginning on Monday, 11/12/18, to ensure structured block activities have been facilitated and documented, as well as the daily psycho-educational groups. -A PQI (Performance Quality Improvement) team representative will attend the required training on Wednesday, 11/14/18, with the Level III Residential Treatment staff to assess for content and delivery. The PQI Director will also identify and assign additional trainings related to Substance Use and Intervention in RELIAS (an online training portal) for Level III Residential Treatment Staff to complete within the next 30 days. -Eliada's Medical Director and Clinical Director will review the PCP revision with updated diagnostic information, goals and intervention strategies by 11/15/18. -**The Residential Director will participate in the	V 293		

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V 293	Continued From page 33 Green/L3 Clinical Case Review meeting to confirm development of the individualized crisis plans and strategies for service delivery on 11/28/18. The Clinical Supervisor for Green Cottage will lead the development of the intervention strategies and provide coaching for staff related to implementation." Client #1 and Client #2 both had histories of extensive substance use, truancy and elopements. The facility failed to have a system in place to meet the complex treatment needs and manage the behaviors of both clients. Random urine drug screening was conducted weekly for both clients, however, there was no urine drug testing policy in place. Staff were unclear about testing procedures and were not consistent in the implementation of that process. Testing supplies were inadequate at times which resulted in inconclusive results. Client #1 and Client #2 on occasion left school premises and there was no system of communication with the local high school that ensured school attendance and their safety. Group therapy for substance abuse was indicated as a needed component in the treatment for both clients but was never fully implemented. Communication with the guardian of Client #1 was problematic and family therapy sessions did not occur. The chronic elopement behaviors that usually occurred when Client #1 was on therapeutic leave went unaddressed for 2 months. Neither treatment plan for Client #1 nor Client #2 indicated strategies to address these behaviors nor did the therapy sessions consistently indicate that these treatment needs were addressed. As a result, Client #1 was out of the facility on unapproved leave eight times for periods of time ranging from 1 to 4 days. She tested positive for marijuana following every extended period of absence. Since admission	V 293		

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V 293	Continued From page 34 Client #1 tested positive for marijuana a total of 11 times. Client #2 experienced two hospital emergency room admissions due to overdose and alcohol intoxication both of which occurred following an elopement from school. Most recently, drugs were brought into the facility by Client #1 after a 4 day elopement. Client #1 kept the drugs on her person knowing that the facility could not conduct a body search. Both Client #1 and Client #2 proceeded to smoke marijuana inside the cottage. These systemic failures to provide services to meet the specific needs of these clients constitute a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1000.00 is imposed. If the violation if not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 293		
V 503	27D .0103 Client Rights - Search And Seizure Policy 10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY (a) Each client shall be free from unwarranted invasion of privacy. (b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client. (c) Every search or seizure shall be documented. Documentation shall include: (1) scope of search; (2) reason for search; (3) procedures followed in the search; (4) a description of any property seized;	V 503		

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V 503	Continued From page 35	V 503		

and
(5) an account of the disposition of seized property.

This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to document scope of search, reason for search, procedures followed in the search, a description of any property seized, and an account of the disposition of seized property for every search or seizure affecting 2 of 3 audited clients (#1, #2). The findings are:

Record review on 11/7/18 and 11/8/18 for Client #1 revealed:
-Admitted on 8/16/18 with diagnoses of Post-Traumatic Stress Disorder and Oppositional Defiant Disorder.

Record review on 11/7/18 and 11/8/18 for Client #2 revealed:
-Admitted on 8/13/18 with diagnoses of Unspecified Depressive Disorder, Other Specified Anxiety Disorder, Cannabis Use Disorder Severe, Sedative, Hypnotic or Anxiolytic Use Disorder Severe, Stimulant Use Disorder Severe and Alcohol Use Disorder Moderate.

Review on 11/9/18 of the Search and Seizure policy revealed:
-" ...when there is reasonable cause to suspect that a client has contraband on their person or within the program, staff/foster parent will conduct a search of the client and/or premises ...Staff/foster parents may search a client and their possessions when they are returning to the program from an off-campus visit or after receiving visitors when it is reasonable to believe the client may have items in their possession that

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V 503	Continued From page 36 are dangerous, illegal ...all searches will be documented and maintained on file ..." Review on 11/9/18 of the "Security Scan Procedure" revealed: -" ...students will engage in a security scan upon arrival to campus. This scan will be completed every time a student enter an Eliada treatment facility after spending time in the community ...students will be directed to remove outerwear, turn out pockets, take off/shake out shoes, turn out waist band, pull up pant legs ...Eliada staff will pass the wand across their arms and down their torso and legs ...students will be prompted to open backpacks and other bags to make the contents visible ..." Review on 11/9/18 of a sample of daily service notes for Client #1 and Client #2 revealed: -On 10/1/18 " ...Staff led bag and body checks on [Client #1] ..." -On 10/1/18 " ...Staff led bag and body searches on [Client #2]. Staff confiscated a cell phone ..." -On 10/2/18 " ...Staff led bag and body searches ...[Client #2] complied with bag and body checks ..." -On 10/3/18 " ...Staff performed a bag and body search before allowing [Client #1] to enter the cottage ..." -On 10/3/18 " ...Staff returned to [cottage] with [Client #2]. Staff led bag and body searches. Staff noticed an empty pack of cigarettes ..." -On 10/5/18 " ...Staff transported [Client #1] back to campus where staff performed a bag and body search before allowing her to enter the cottage ..." -Documentation did not include scope of search, reason for search, procedure followed in search, description of property seized or disposition of seized property.	V 503		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-371	A. BUILDING: ______ B. WING ______	C 11/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 503	Continued From page 37 Interview on 11/8/18 with Residential Counselor #1 revealed: -Clients were searched every time they had been off campus. -Clients were required to empty pockets and shake out underwear/bra/clothing and remove shoes. Interview on 11/7/18 with Residential Counselor #4 revealed: -When clients returned to the cottage from school or from therapeutic leave a search and scan was completed. Staff used a wand over their body and searched any bags. Clients were required to empty pockets, shake out baggy clothing, turn down the rim of their socks and take off shoes. This was documented in their service note. Interview on 11/9/18 with the Residential Services Director revealed: -Scans were conducted on clients after returning to campus from school or if they had been in the community. -These "scans" were not documented as search and seizure.	V 503		