An annual and complaint survey was completed on April 8, 2019. The complaint was substantiated (Intake #NC00147776). Deficiencies were cited.

This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.

10A NCAC 27G .0203 Privileging/Training Professionals

(a) There shall be no privileging requirements for qualified professionals or associate professionals.

(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.

(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.

(d) Competence shall be demonstrated by exhibiting core skills including:

(1) technical knowledge;
(2) cultural awareness;
(3) analytical skills;
(4) decision-making;
(5) interpersonal skills;
(6) communication skills; and
(7) clinical skills.

(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.

(f) The governing body for each facility shall develop and implement policies and procedures...
Continued From page 1

for the initiation of an individualized supervision plan upon hiring each associate professional.

(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.

This Rule is not met as evidenced by:

Based on record review, and interview the facility failed to ensure that 1 of 1 Qualified Professionals (Director/QP) demonstrated knowledge, skills and abilities required by the population served. The findings are:

Review on 3/19/19 of the personnel record for the Director/QP revealed:

- Hired 10/7/11.
- Met qualifications for QP.

See V112 for additional information.

Interviews on 3/6/19 and 3/19/19 with the Director/QP revealed:
- She was responsible for identifying short term goals for each client and the development of their treatment plan. She was also responsible for staff supervision.
- Former Client #4 (FC #4) was admitted in November 2018. He ran away soon after admission. She issued a 30 day notice. She had talked to his guardian about placement at that time into a crisis bed but that fell through. FC #4 agreed to improve his behaviors and the 30 day notice was rescinded. The notice was issued again in early January 2019. "He did not want to be here."
### Summary Statement of Deficiencies

- **V 109**: Continued From page 2
  - FC #4 would walk off the property and go to a neighbor's home and claim he was mistreated.
  - FC #4 targeted the House Manager.
  - He wanted to smoke cigarettes and marijuana. He would sell his clothes to buy marijuana.
  - There was a lot of law enforcement involvement with FC #4.
  - FC #4 brought in contraband. The only contraband she was aware of was lighters and cigarettes. She never saw any marijuana. She placed any contraband that was confiscated in a plastic bag and removed it from the facility.
  - FC #4 went to school and tried to sell his clothing for lighters and cigarettes. She stated that she talked to the school principal about it.
  - FC #4 wanted to smoke and ran away to get cigarettes. They did not know about his nicotine addiction.
  - FC #4 did not want to participate in the program. She thought his behaviors were an effort to get discharged.
  - She felt he exceeded level 2 due to his risky behaviors and non-compliance. He was given a 30 day notice.
  - Supervision for FC #4 was difficult during the times he wanted to run away.
  - Staff were always to be where the clients were. Staff would have to be at the door if a client was outside so that they could also see the other clients at the kitchen table.
  - She did not feel that 2 staff were needed in the facility. Two staff were only needed when FC #4 was running away.
  - The staffing ratio was never increased in the facility.
  - If FC #4 would give up his contraband he would come on in to the facility. If not the police would come to conduct a search and FC #4 would wait outside.
  - FC #4 was always allowed inside.
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<tr>
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<td>27G .0204 Training/Supervision Paraprofessionals</td>
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- She had not been informed by law enforcement or the social worker that the facility door was shut when FC #4 was outside on 1/22/19.
- The House Manager indicated that the police officer misunderstood what had happened on 1/22/19.

This deficiency is cross referenced into 10A NCAC 27G Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.

10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS
(a) There shall be no privileging requirements for paraprofessionals.
(b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter.
(c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served.
(d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.
(e) Competence shall be demonstrated by exhibiting core skills including:
(1) technical knowledge;
(2) cultural awareness;
(3) analytical skills;
(4) decision-making;
(5) interpersonal skills;
(6) communication skills; and
(7) clinical skills.
(f) The governing body for each facility shall
This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to ensure that 1 of 2 audited paraprofessional staff (House Manager) demonstrated knowledge, skills and abilities required by the population served. The findings are:
Review on 3/19/19 of the personnel record for the House Manager revealed:
-Hired 10/18/13.
-Met qualifications for a paraprofessional staff member.
See V112 for additional information.
Interview on 3/19/19 with the Child Protective Services Social Worker for the local Department of Social Services revealed:
-The House Manager admitted to her that he told Former Client #4 (FC #4) that he could not enter the facility until he handed over his contraband. He also admitted that FC #4 was left outside and the facility door was closed. He told her that he did not know that he couldn’t do that.
-She informed the House Manager that he could not do that. He informed her that as an alternative he would have FC #4 sit on the porch and he would keep the door open.
-The House Manager informed her that on other occasions FC #4 would be outside and he would...
## Statement of Deficiencies and Plan of Correction

### Provider/Supplier/CLIA Identification Number:

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### Date Survey Completed:
04/08/2019

### Name of Provider or Supplier:

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<tr>
<td>103 EBENEZER ROAD</td>
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<td>KINGS MOUNTAIN, NC 28086</td>
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### Summary Statement of Deficiencies:

**Continued From page 5**

- The House Manager also indicated that now he had to take FC #4's shoes out of his bedroom because he was running so much.

Interview on 3/15/19 with a dispatcher for the local Sheriff's Department revealed:

- 11/24/18 elopement of FC #4, called in at 3:04PM. FC #4 returned to the facility at 6:24PM. He was picked up in a neighboring county approximately 2 miles away.

- 1/6/19 elopement of FC #4 called in at 4:08PM. FC #4 was returned at 4:30PM. No location identified.

- 1/7/19 elopement of FC #4 called in at 6:12PM. No return time or location of pick up identified.

- 1/13/19 disturbance at the facility that involved FC #4. Police were on site.

- 1/14/19 elopement of FC #4 called in at 11:51AM. No return time or location of pick up identified.

- 1/20/19 elopement of FC #4 called in at 4:48PM. FC #4 returned to the facility at 5:31PM. He had been picked up near the local bypass approximately 3 miles away.

- 1/22/19 report of van keys missing. Police on site.

- 1/28/19 report of possible drug use. Police on site. No person identified.

- 2/5/19 elopement of FC #4 called in at 6:33PM. FC #4 was returned at 7:18PM. No location identified.

- 2/6/19 elopement of FC #4 called in at 7:28PM. He was returned at 9:27PM. He was picked up approximately three quarters of a mile away.
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<tr>
<td>Interview on 3/8/19 with the deputy of the local Sherriff's Department revealed:</td>
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<td>- She responded to a call on 1/22/19 that van keys were missing at the facility.</td>
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<td>- When she arrived on site FC #4 was outside down the long driveway that leads to the house. He did not have a coat on and the temperature outside was in the 30's.</td>
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<td>- She went to the door and staff unlocked the door. She stated that the door was locked.</td>
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<td>- The House Manager told her that they would not let him back in until they found the van keys. She stated that FC #4 denied that he had the keys.</td>
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<td>- The House Manager then stated &quot;until the keys are found he's not coming back in.&quot;</td>
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<td>- She informed the House Manager &quot;that was unacceptable.&quot; The House Manager then agreed to let FC #4 go to his room.</td>
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<td>- FC #4 told her that the House Manager &quot;was always locking me out.&quot;</td>
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<td>- When she left FC #4 was in the house and the House Manager had agreed not to make him stay outside.</td>
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<td>Interviews on 3/7/19 and 3/11/19 with the House Manager revealed:</td>
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<td>- He was the staff member on second shift. He also worked sometimes on first shift if there was an out of school suspension.</td>
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<td>- Staff were always to have eyes on the clients. If a client was outside staff was to be outside. The staff and clients were to be all outside together or all inside together. These were the expectations even when FC #4 was there.</td>
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<td>- FC #4 would walk out of the facility and refuse to come back in. If FC #4 walked outside he would stand in the doorway and have the other clients sitting at the table which was in his direct view from the doorway.</td>
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<td>- When FC #4 started at the alternative school he</td>
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started bringing in contraband. He had a marijuana pipe, box of tobacco, lighters, partial cigarettes, black and mild's, marijuana and small cylinders that resembled a bullet casing.
- The other clients would inform him that FC #4 had contraband.
- FC #4 was stopped at the door and asked to surrender the contraband. Sometimes he would comply and sometimes he would go into the yard. FC #4 would refuse to turn over the contraband and walk around in the yard then come to the door and say he was ready. He was then searched and if clear they would let him in.
- There were times he contacted law enforcement to come on site and search FC #4. FC #4 would sit on the porch and wait or he was allowed to come in the facility and sit on the couch.
- FC #4 was never forced to stay outside. He made the choice to stay outside.
- Law enforcement came multiple times to conduct searches.
- Sometimes FC #4 would stand at the door yelling into the house. At times FC #4 tried to grab the van keys.
- On 1/22/19 he was washing dishes and FC #4 grabbed the van keys off the desk in the kitchen and then sat down at the kitchen table with the other clients.
- FC #4 told the other clients that he had the van keys. FC #4 told him that he had the keys.
- FC #4 then got his jacket and said he was leaving. FC #4 went outside and was walking around the van in the yard. He called the QP and the police. He stated he was at the door and the other clients were at the table in the kitchen within his view.
- He stated that the door was cracked open, not shut or locked. He was the only staff working on that date. He repeatedly asked FC #4 to come in.
- On 3/11/19 he indicated that on 1/22/19 he was...
Continued From page 8

in the living room with the door wide open watching FC #4 so that FC #4 didn't get in the van.
-When the police officer arrived FC #4 came up to the porch and sat down. The front door was open.
-When asked by the police officer FC #4 denied he had the van keys. FC #4 told the officer he was made to stay outside.
-FC #4 and the police officer came inside and talked. The police officer left and then FC #4 went back outside. The social worker then arrived.
- The social worker interviewed him and all the clients. He explained to the social worker that FC #4 was not going to be outside.
-He stated he never threatened to lock FC #4 out of the facility. He stated that FC #4 told him that he would do everything he could to get him fired.
-He stated that they could not stop him from running away.

This deficiency is cross referenced into 10A NCAC 27G Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.

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- **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...
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 1 of 1 former clients (FC #4). The findings are:

Record review on 3/6/19 for FC #4 revealed:
-Admitted on 11/15/18 with diagnoses of Oppositional Defiance Disorder, Post-Traumatic Stress Disorder, Major Depression, and moderate Intellectual Disability.
-Discharged 2/7/19.
-Age 14.
-History of sexual abuse, neglect, loss and grief.
The Department of Social Services took custody following his mother's death due to overdose.
-History of behaviors included angry mood, defiance, vindictiveness, argumentative with authority, lying and blaming others.
Review on 3/6/19 of the Treatment Plan for FC #4 revealed:

- Treatment plan dated 10/12/18 included a goal of "...[FC #4] will follow the curfew guidelines at the facility and at home, remain in his assigned area at night and display no AWOL (absent without official leave) behavior ...",
- Strategies for this goal (in 10/12/18 treatment plan) and all goals were "...provide structured 24/7 residential services with rules, routine and structure ... provide individualized and intensive supervision of structure of daily living in order to help minimize the occurrence of behaviors related to [FC #4's] functional deficits and to ensure his safety when such out of control behaviors or crisis situations arise ... provide psychoeducational and therapeutic interventions ...
- development of daily living skills, anger management, healthy social skills, appropriate boundaries and peer interactions, communication skills, stress management, relationship support and crisis management to include de-escalation interventions including physical restraints/therapeutic holds when necessary ...
- monitor/followup, arrange, refer/link, assess, plan, and coordinate services for consumer ...
- assist him with reducing his defiant behavior at home ... address his social behaviors, assist ... in identifying the characteristics of good friend versus friends that ... lead him into trouble ...
- implement various strategies and interventions (role modeling, role playing, redirection, prompts, mentoring, anticipatory guidance, etc.) ...
- Crisis plan indicated "... ways others can help me ...
- Close, line of sight or in group settings, arm's length supervision, is important, especially in the community ..."

- Update to the treatment plan on 12/10/18 indicated "...[FC #4] displays unsafe behaviors AWOL, not following safely measure in the facility
Continued From page 11

...[FC #4] has stated to staff the has urges for smoking cigarettes and he use to smoke marijuana ...struggle with following safety rules and has AWOL behaviors with being back at the facility a couple hours later ...goal not met ..."

-Update to the treatment plan on 1/08/19 indicated " ...[FC #4] has AWOL behaviors and states that he has a difficult time with urges to smoke cigarettes and weed ...[FC #4] is non-compliant when interacting with them with following rules ...[FC #4] has shown deceptive behaviors ...poor decision making ...not accepting to the program ...goal has not been achieved ...refuses treatment ..."

-Update to the treatment plan on 2/07/19 indicated " ...[FC #4] will be discharged as of today. [FC #4] has been noncompliant, unsafe, demonstrating risky behaviors ...[FC #4] has AWOL behaviors ...does not come into the facility and will stay out side until its time for medication and bed time. 5 out of 7 night ...will not give up the contrabands ..."

-No additional or new strategies added to the treatment plan as the behaviors of FC #4 began to escalate and the elopements began to increase.

Review on 3/11/19 of the daily service notes for FC #4 revealed:
-On 1/6/19 " ...viewed consumer to walk off site. Staff contacted police for support. Staff thanks police for escorting consumer back to the facility ...

-On 1/7/19 " ...staff reminded consumer of searching him before he arrives at the facility due to having suspicion of drugs and cell phone ...staff informed consumer therapist of the AWO behavior, noncompliant and no following safety rules ...Staff informed coworker of consumer behaviors during shift change and needing to
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search him before he enters the facility ..."
Signed by the Director/Qualified Professional (Director/QP).

-On 1/7/19 3:00PM-9:00PM " ...Staff greeted consumer upon arrival and processed with the consumer about him having contraband on his person. Staff calmly explained to the consumer that he has turn over all of the contraband before he enters the facility to ensure the safety of others as well as himself ...staff eventually got the consumer to give up a few items of contraband. Staff called the local authorities to ensure that the consumer did not have anymore items ...staff called the local authorities and informed them of the consumer going AWOL ..."

-On 1/14/19 " ...staff monitored the consumer to run up the driveway and yell out inappropriate comments. Staff called the local authorities and informed them of the situation. Staff received a phone call from the local authorities stating that the consumer was found at a neighbor's home. Staff informed the consumer that he needed to give up his foreign objects as well as contraband before he is able to enter the facility ...consumer was brought back by the local authorities ..."

Review on 3/11/19 of a Director/QP Note dated 1/22/19 revealed:

-"QP (Director/QP) spoke with staff to learn consumer had taken van key and would not give the item up. QP learned staff contacted the local authorities to address this issue with a search. QP was informed consumer stated to have the key and then later say he does not. QP learned from staff consumer stated that they heard consumer say he has the van key ...QP arrived at facility with other staff to learn the officer from earlier heard Self Determination staff state he was going to lock consumer out for the facility which cause the officer to file a complaint ..."
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** MHL023-197

**A. Building:**

**B. Wing:**

**Date Survey Completed:** 04/08/2019

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**Self Direction**

**Street Address, City, State, Zip Code:**

103 Ebenezer Road  
Kings Mountain, NC  28086

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### Summary Statement of Deficiencies

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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Review on 3/6/19 of the facility incident reports revealed:

- On 1/6/19 "...Consumer went on a outing in the community and when returned for shift change consumer did not want to get out to the van. Consumer had cigertted butts on him that he picked up on the parking lot when he was on his outing for lunch with peers and staff.  Consumer walked of site of the facility ...staff contacted local authority for support ...consumer returned with police ...".

- On 1/8/19 "...Consumer was non compliant to follow the rules of the facility and walked away ...Staff received phone call from police consumer was located at a persons home in another town. Police retrieved consumer from the persons home and returned back the facility safely ...

- On 1/11/19 "...Staff attempted to have the consumer leave the facility with the group but hew refused.  The consumer stated that he can do whatever he wants and started to run away.  Staff called local authorities and informed them ...Staff received a phone call from the authorities informing him that the consumer was found at [local alternative school] ..."

Interview on 3/13/19 with FC #4 revealed:

- "They locked me out."

- He indicated that he was searched every day.

- Sometimes he did not agree to be searched and the House Manager said would have to make a phone call to see if he could come in the house.

- He ran away almost every day.  He stated he went to another area in the county which was approximately 3 hours by foot.  The police would bring him back.

- The contraband he had was tobacco and a phone.  He denied he had marijuana.  He stated that some other students at school has showed...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**STATE FORM 63HU11**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**NAME OF PROVIDER OR SUPPLIER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**SELF DIRECTION**

**103 EBENEZER ROAD**

**KINGS MOUNTAIN, NC 28086**

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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him marijuana but he did not want it.

-"I thought if I can't come in I will go somewhere else."

-The House Manager said "you can't come in, I have to make a phone call." He would call the Director/QP. He would remain on the porch or walking outside around the house. He stated that he was not given the option to come in and wait inside.

-When he was outside the front door was closed and locked. He stated he tried to get in the door and it was locked. He stated that it was cold outside and the House Manager would not let him get his coat.

-The police came about every day.

-When he was in the yard the door was closed and no staff were outside. He further stated that no staff member checked on him. There was one staff working at a time.

-He sat most days on the porch because he had to. The House Manager would be somewhere in the house. The QP was not there.

-He ran away almost every day.

-He was blamed for the missing van keys. He stated that he did not take them. He ran away and the police brought him back. A social worker met with him the night that the van keys were missing.

Interviews on 3/11/19 and 3/12/19 with the Guardian for FC #4 revealed:

-Within the first 3 days FC #4 was running.

-"Running was never one of his behaviors."

-On the second day of his placement they issued a 30 day notice which they rescinded but later reinstated.

-FC #4 stated that he did not like the way he was treated there and wanted to be adopted. He reported to her "they are mean to me" and "I don't like it here".

**STATE FORM** 63HU11

If continuation sheet 15 of 40
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- "It was clear from the third day they did not want him there."
- From early January 2019-February 7 he was running every day.
- FC #4 told her that they would not let him back in the house after running away and locked him out.
- On the day the van keys were missing FC #4 told them numerous times he didn't have the keys. He ran away and went to a neighbor's house and called the local Sheriff's department to report he was locked out of the facility. This was the only time he ever initiated a call to law enforcement.
- She did not feel that he was lying or had the capability to provide details of an event.
- She indicated that while placed at the facility "his agitation level was so high."
- "Not the same child she had been dealing with for the last 2 years."
- After his discharge, FC #4 went to a crisis center then to respite and was now in a therapeutic foster home. FC #4 had not run away from any of the follow up placements.
- The Director/QP reported the elopements to her as well as the contraband of tobacco.
- She further added that part of the problem was on FC #4. He was running and made the placement difficult.
- She stated that FC #4 had always maintained open communication with her but during this placement he did not want to talk to her. She did not understand why.
- The facility accused him of smoking marijuana because they smelled an odor in his room. A urine drug screen was conducted and was negative. She indicated that drugs had never been an issue for him. She was not aware of any time he possessed or had smoked marijuana during the placement.

Interview on 3/15/19 with a dispatcher for the Division of Health Service Regulation
V 112 Continued From page 16

local Sherriff's Department revealed:
-11/24/18 elopement of FC #4, called in at 3:04PM. FC #4 returned to the facility at 6:24PM. He was picked up in a neighboring county approximately 2 miles away.
-1/6/19 elopement of FC #4 called in at 4:08PM. FC #4 was returned at 4:30PM. No location identified.
-1/7/19 elopement of FC #4 called in at 6:12PM. No return time or location of pick up identified.
-1/13/19 disturbance at the facility that involved FC #4. Police were on site.
-1/14/19 elopement of FC #4 called in at 11:51AM. No return time or location of pick up identified.
-1/20/19 elopement of FC #4 called in at 4:48PM. FC #4 returned to the facility at 5:31PM. He had been picked up near the local bypass approximately 3 miles away.
-1/22/19 report of van keys missing. Police on site.
-1/28/19 report of possible drug use. Police on site. No person identified.
-2/5/19 elopement of FC #4 called in at 6:33PM. FC #4 was returned at 7:18PM. No location identified.
-2/6/19 elopement of FC #4 called in at 7:28PM. He was returned at 9:27PM. He was picked up approximately three quarters of a mile away.

Interview on 3/6/19 with Client #1 revealed:
-FC #4 was always trying to bring lighters and drugs into the facility. He would inform the House Manager that FC #4 had contraband.
-FC #4 would stay on the porch until he gave up his contraband.
-He would be outside 30-45 minutes but would finally give up the contraband.
-Sometimes FC #4 wanted to be outside.
-Police came multiple times bringing FC #4 back
Continued From page 17

to the facility.
-FC #4 would run every other day.
-The House Manager was always respectful.
One time, while on the porch, FC #4 blew smoke
in the House Managers face and the House
Manager would close the door.

Interview on 3/6/19 with Client #2 revealed:
-It was stressful with FC #4 there.
-The House Manager said "you ain't coming into
the house until you give up the drugs." FC #4
said he didn't want in the house. FC #4 would
then give up his stuff and come in.
-FC #4 would be outside 30 min to an hour.
-The House Manager would call the police to
come search FC #4.

Interview on 3/6/19 with Client #3 revealed:
-FC #4 chose not to come in the house. He didn't
want to give up the contraband he had.
-The House Manager said FC #4 couldn't come
back in the house until he gave up his
contraband.
-Sometimes FC #4 would run away.

Interview on 3/7/19 with Staff #1 revealed:
-There was usually one staff working, sometimes
two.
-FC #4 ran on second shift a lot. He would be
gone anywhere from 1-3 hours.
-When he got home from school FC #4 would be
asked to empty his pockets.
-Police would conduct body searches.
-The front door was not locked.
-If FC #4 did not want to empty his pockets he
would have to stay at the door. He would usually
empty his pockets after 20-30 minutes.
-He indicated that they did not know what he
might try to bring in.
-FC #4 also liked to be outside. When he was
Continued From page 18

working he would walk back and forth to the door to watch him. He was not outside with FC #4 at those times to provide constant supervision.

-FC #4 was never outside at night.

Interviews on 3/7/19 and 3/11/19 with the House Manager revealed:

-He was the staff member on second shift. He also worked sometimes on first shift if there was an out of school suspension.

-When asked about strategies used to address the running behaviors, he stated that he tried to encourage FC #4 and engage him in the program. He tried to help FC #4 improve the relationship he had with the other clients.

-He tried to build trust with FC #4 and tried to motivate him to improve. They also tried to give him candies and gum to discourage him from walking off to get cigarette butts.

-No other changes with FC #4 were implemented. No new strategies were put in place.

Interviews on 3/6/19 and 3/19/19 with the QP revealed:

-FC #4 did not have a strong history of running, there may have been only one prior time that had occurred.

-She was responsible for treatment planning for each client. There was a child and family team meeting monthly. Based on information obtained in that meeting as well as daily progress reports the treatment plan would be updated monthly. She also met weekly with the House Manager to get feedback or concerns about clients.

-The only strategies she indicated were implemented were giving him candies or gum to help with the urges and allowing him to call his social worker anytime he wanted to.

-No changes were implemented to address the escalating behaviors of FC #4. No increase in
V 112

Continued From page 19

staffing was implemented. They were focused on finding him another placement.
- The treatment plan was never updated. No new strategies were indicated in the treatment plan.
- She usually requested an emergency CFT (child and family team) meeting when behaviors began to increase. There had been an emergency CFT initially after the first elopement. There were no other emergency meetings conducted to address the increased elopements of FC #4 during January.

Interview on 3/19/19 with the Child Protective Services Social Worker for the local Department of Social Services revealed:
- She was on site at the facility on 1/22/19 in response to a report. She interviewed the staff and the current children that lived in the facility.
- The Director/QP denied that any children were locked out of the facility.
- The other clients interviewed stated that no one was locked out of the house.
- FC #4 reported to her that when he was in trouble they would lock him out. He stated that sometimes they searched him and sometimes they didn't but they would not believe him and locked him out anyway.
- FC #4 stated he had been locked out approximately 6 times. He stated that when he left they would lock the door behind him.
- She stated that FC #4 made it clear he did not want to be in that home.
- Their case was unsubstantiated.

This deficiency is cross referenced into 10A NCAC 27G Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER:
SELF DIRECTION
STREET ADDRESS, CITY, STATE, ZIP CODE:
103 EBENEZER ROAD
KINGS MOUNTAIN, NC  28086

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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>27G .0209 (C) Medication Requirements</td>
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<td>(c) Medication administration:</td>
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<td>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</td>
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<td>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</td>
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<td>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</td>
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<td>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</td>
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<td>(B) name, strength, and quantity of the drug;</td>
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<td>(C) instructions for administering the drug;</td>
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<td>(D) date and time the drug is administered; and</td>
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<td>(E) name or initials of person administering the drug.</td>
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<td>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</td>
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This Rule is not met as evidenced by:
Based on observation, record review and interviews the facility failed to ensure medications
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were administered as ordered and failed to ensure MARs were current for 2 of 3 current clients (#2, #3). The findings are:

Record review on 3/6/19 for Client #2 revealed:
-Admitted on 9/12/18 with diagnoses of Oppositional Defiance Disorder, Mood Dysregulation Disorder, and Attention Deficit Hyperactivity Disorder.
-Age 13.
-Physician's order dated 12/28/18 for Lamotrigine (used to prevent extreme mood swings) 100mg, 1 in the morning. The order was changed to on 1/28/19 to PM administration.
-Physician's order dated 11/30/18 for Escitalopram (used for depression and anxiety) 10mg, give 1 in the PM. Physician's order dated 12/28/18 changed the administration to the AM. The order for administration changed back to PM on 1/28/19.

Review on 3/6/19 of the January 2019-March 2019 MARs for Client #2 revealed:
-The Lamotrigine was charted twice daily in February.
-The Escitalopram was documented in the AM during the months of January and February.

Record review on 3/6/19 and 3/19/19 for Client #3 revealed:
-Admitted on 11/19/18 with diagnoses of Major Depressive Disorder, Post-Traumatic Stress Disorder, Child Neglect and Child Physical Abuse, and Child Sexual Abuse.
-Age 12.
-Physician's order dated 11/13/18 for Ocean Spray nasal spray .65%, 2 sprays each nostril daily. The order did not indicated to use as needed.
Review on 3/6/19 and 3/19/19 of the January 2019-March 2019 MARs for Client #3 revealed:
- Nasal spray administration was not documented.

Interview on 3/7/19 with the House Manager revealed:
- Medications were counted daily.
- MARs were reviewed daily. Either he or the Qualified Professional would update MARs.
- He confirmed that Client #2 did not receive Lamotrigine twice daily during February.

Interview on 3/7/19 with the Qualified Professional revealed:
- She had not corrected the Lamotrigine on the February MAR for Client #2. He was not administered the medication twice daily.
- She had failed to update the MARs with changes.
- The Escitalopram was not changed back to evening administration until 3/1/19. There had been some confusion when Client #2 saw another psychiatrist briefly.
- Client #3 was admitted with nasal spray but she believed it to be for PRN (as needed) use only.
- He had never had a need for it to be used routinely.

- She and the House Manager did the oversight for medication administration. MARs were to be updated with any changes. The pharmacy conducted reviews.

This deficiency is cross referenced into 10A NCAC 27G Scope (V179) for a Type A1 rule violation and must be corrected within 23 days.
(a) The rules of this Section apply only to a residential treatment facility that provides residential treatment, level II, program type service.

(b) A residential treatment facility providing residential treatment, level III service, shall be licensed as set forth in 10A NCAC 27G .1700.

(c) A residential treatment facility for children and adolescents is a free-standing residential facility which provides a structured living environment within a system of care approach for children or adolescents who have a primary diagnosis of mental illness or emotional disturbance and who may also have other disabilities.

(d) Services shall be designed to address the functioning level of the child or adolescent and include training in self-control, communication skills, social skills, and recreational skills. Children or adolescents may receive services in a day treatment facility, have a job placement, or attend school.

(e) Services shall be designed to support the child or adolescent in gaining the skills necessary to return to the natural, or therapeutic home setting.

(f) The residential treatment facility shall coordinate with other individuals and agencies within the client's system of care.

This Rule is not met as evidenced by:

Based on record review and interviews the facility failed to ensure a structured living environment within a system of care approach that was
Provided deficiencies and plan of correction for the provider/supplier/CLIA identification number MHL023-197. The date of survey completed is 04/08/2019.

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- Designed to address the functional level of 1 of 1 former clients (FC #4) and 2 of 3 current clients (#2, #3). 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 1 of 1 former clients (FC #4).

  - Cross Reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109). Based on record review, and interview the facility failed to ensure that 1 of 1 Qualified Professionals (Director/QP) demonstrated knowledge, skills and abilities required by the population served.

  - Cross Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). Based on record review and interviews the facility failed to ensure that 1 of 2 audited paraprofessional staff demonstrated knowledge, skills and abilities required by the population served.

  - Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V118). Based on observation, record review and interviews the facility failed to ensure medications were administered as ordered and failed to ensure MARs were current for 2 of 3 current clients (#2, #3).

Review on 3/19/19 of the Plan of Protection signed and dated by the Director/QP on 3/19/19 revealed:

- "What will you immediately do to correct the
## Statement of Deficiencies and Plan of Correction

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### Name of Provider or Supplier

**Self Direction**

103 Ebenezer Road
Kings Mountain, NC 28086

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### Summary Statement of Deficiencies

**V 179** Continued From page 25

above rule violations in order to protect clients from further risk:

- "10A NCAC 276.301 Scope
  Self Determination, LLC will implement new strategies and interventions to support consumer that exceed the program for Level II program by contacting the on call QP and assessing the incident for what strategy is needed. Additional staff will be implemented for one on one to support consumer supervision as needed."

- "10 NCAC 276.0205 Assessment and treatment/Habilitation or service plan:
  QP will address the incident by conducting an assessment created to address any at risk behaviors along with the appropriate strategy and intervention to support the behavior and will update treatment plan with change to reflect changes to relate to the consumer goals (whom, what, where, Frequency) and in Crisis plan at the monthly CFT. QP will obtain information from the guardian if consumer has escalated behaviors and establish emergency meeting to address these unwarranted behaviors. Training for staff will take place when there is change to the treatment plan. QP 1 and QP2 will also conduct review over current consumers treatment plan for revisions, updates , revised with new strategies as needed"

- "10A NCAC 276.0203 Competencies of Qualified Professionals and Associate professionals
  QP 1 will immediately take the role of supervising QP 2 by monitoring and supervising to increase QP 2 responsibility of incident reporting and assessment of incident when consumer demonstrates at risk behaviors. Self Determination, LLC will search for additional trainings for at risk behaviors for the next 30 days. Effective immediately treatment plans QP
### Summary Statement of Deficiencies

The statement outlines issues in the provider's operations and the plan of correction for each deficiency. It includes the following points:

**1.** Conducting weekly meetings with QP 2 to consult about each consumer evaluation and strategies determined and revision of the plan. As the treatment plan is reviewed, new strategies will be added to the progress note. QP 2 will present the progress note to the CFT. Qp1 will debrief after consumer has escalate behaviors to support consumers needs with new strategy or what staff can do differently.

**2.** Supervision of paraprofessional: QP 1 will supervise monitor paraprofessional on site and during community outings to assure Para professional is making appropriate decisions making for well being of consumer when behaviors have escalated. Qp1 will search for any available training through the MCO or reach out to Provider for Training to support core competence addressing decision making all training will be placed in staff charts for further references. Qp1 will debrief after consumer has escalate behaviors to support consumers needs with new strategy or what staff can do differently.

Describe your plan to make sure the above happens:

- Qp 1 will reassure all the above is implemented within the 23 days. Qp will implement the retraining para professional by 3/22/2019. Qp1 will provide supervision and weekly meetings and documentations will be submitted into staff charts. 3/22/2019
- QP will conduct weekly meeting with staff to assure any trouble shooting, barriers and assure all documentation is completed that is required for incident reporting, strategies and interventions being used to support consumer well being in level II for safety and decrease in lowering risky behaviors.
Review on 4/8/19 of the Plan of Protection Addendum completed on 4/8/19 by the Director/QP revealed:

- "Addendum ...Medication Start date of 4/8/2019QP 1 will immediately monitor MARS book so assure medication is being documented appropriately along with Audit form. QP will meet with pharmacist to assure weekly mediation is documented properly bi weekly. QP 1 will conduct weekly audit of MARS book to assure accuracy. QP 1 will discuss and review with house manager to assure medication is being administrated and monitored properly weekly. QP 1 will meet with registered nurse for observation of documentation of medication and MARs sheet to assure compliance by 4/26/2019. QP 1 will supervise and monitor QP weekly to assure compliance and able to return to QP standards QP will meet monthly with registered nurse for review of MARS sheets for support for monitoring purposes."

FC #4 is age 14 and had a history of neglect and defiance against authority figures. He was admitted to the facility with a goal to eliminate elopement behaviors and the crisis plan indicated that he was best served with line of sight supervision, especially in the community. Almost daily, FC #4 was refused entry into the home when he refused to surrender contraband brought from school. Elopements began to increase and prior to discharge he had eloped 9 times, each time unsupervised in the community anywhere from 30 minutes to 3 hours. As the elopements began to increase the current treatment strategies were not assessed or changed and no new strategies were implemented to ensure his safety. The facility failed to implement their protocol for supervision and never increased the...
**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/CLIA Identification Number:** MHL023-197

**Date Survey Completed:** 04/08/2019

**Name of Provider or Supplier**

**Street Address, City, State, Zip Code**

103 Ebenezer Road

Kings Mountain, NC 28086

**Summary Statement of Deficiencies**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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Staffing ratio to provide the level of supervision needed by FC #4. On 1/22/19 law enforcement responded to the home after receiving a report that the facility van keys were missing. Upon arrival to the home the deputy found FC #4 in the driveway, unsupervised and the facility door locked. The House Manager suspected that FC #4 was in possession of the van keys and left him outside with the van unsupervised, without a coat in temperatures of 30 degree range. The House Manager refused to allow FC #4 into the facility until instructed by law enforcement to do so. FC #4 was consistently running into the community and found to be at the home of strangers, at a school or other local establishments. The QP failed to address the escalating behaviors of FC #4 and failed to ensure that his supervision needs were met. Additionally, the QP failed to have checks and balances in place to ensure proper administration and documentation of medications. The system in place failed to ensure that changes in psychotropic medications were implemented as ordered and properly documented. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty 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 imposed for each day the facility is out of compliance beyond the 23rd day.

**Incident Response Requirements**

10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS

(a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies...
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shall require the provider to respond by:

1. attending to the health and safety needs of individuals involved in the incident;
2. determining the cause of the incident;
3. developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;
4. developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;
5. assigning person(s) to be responsible for implementation of the corrections and preventive measures;
6. adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
7. maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.

(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.

(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider’s premises. The policies shall require the provider to respond by:

1. immediately securing the client record by:
   A. obtaining the client record;
   B. making a photocopy;
   C. certifying the copy’s completeness; and
   D. transferring the copy to an internal review team;
Continued From page 30

(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
   (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
   (B) gather other information needed;
   (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
   (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and

(3) immediately notifying the following:
   (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
   (B) the LME where the client resides, if
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** MHL023-197

**Multiple Construction B. Wing:**

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**Self Direction**

103 Ebenezer Road  
Kings Mountain, NC 28086

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### Summary Statement of Deficiencies

(Each deficiency must be preceded by full regulatory or LSC identifying information)

This Rule is not met as evidenced by:

**Continued From page 31**

Based on record review and interview the facility failed to implement written policies governing their response to level I incidents. The findings are:

- Record review on 3/6/19 for FC #4 revealed:
  - Admitted on 11/15/18 with diagnoses of Oppositional Defiance Disorder, Post-Traumatic Stress Disorder, Major Depression, and moderate Intellectual Disability.
  - Discharged 2/7/19.
  - Age 14.

- Review on 3/11/19 of the daily service notes for FC #4 revealed:
  - On 1/7/19 "...staff reminded consumer of searching him before he arrives at the facility due to having suspicion of drugs and cell phone ..." Signed by the Director/Qualified Professional (Director/QP).
  - On 1/7/19 3:00PM-9:00PM "...Staff greeted consumer upon arrival and processed with the consumer about him having contraband on his
Continued From page 32

person. Staff calmly explained to the consumer that he has turn over all of the contraband before he enters the facility to ensure the safety of others as well as himself...staff eventually got the consumer to give up a few items of contraband. Staff called the local authorities to ensure that the consumer did not have anymore items ...

-On 1/14/19 "...Staff informed the consumer that he needed to give up his foreign objects as well as contraband before he is able to enter the facility ...

Interview on 3/7/19 with the House Manager revealed:
-Searches involved having the client empty all their pockets. They did not put hands on the clients.
-FC #4 started bringing in contraband and that's why they started search and seizure.
-They never really did any searches before FC #4 was admitted.
-FC #4 was searched daily after school.
-Now they routinely search any clients from the alternative school. All pockets are emptied.
-They had never documented the searches and he was not aware of the requirement.

Interview on 3/19/19 with the Qualified Professional revealed:
-She did not know that search and seizure had to be documented as level I incident reports.

27G .0604 Incident Reporting Requirements

10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS
(a) Category A and B providers shall report all level II incidents, except deaths, that occur during
### Summary Statement of Deficiencies

The provision of billable services or while the consumer is on the provider's premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:

1. Reporting provider contact and identification information;
2. Client identification information;
3. Type of incident;
4. Description of incident;
5. Status of the effort to determine the cause of the incident; and
6. Other individuals or authorities notified or responding.

**(b)** Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:

1. The provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
2. The provider obtains information required on the incident form that was previously unavailable.

**(c)** Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:

1. Hospital records including confidential information;
2. Reports by other authorities; and
V 367  Continued From page 34

(3) the provider’s response to the incident.

(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).

(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:

(1) medication errors that do not meet the definition of a level II or level III incident;

(2) restrictive interventions that do not meet the definition of a level II or level III incident;

(3) searches of a client or his living area;

(4) seizures of client property or property in the possession of a client;

(5) the total number of level II and level III incidents that occurred; and

(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure Level II incidents were reported to the Local Management Entity (LME) within 72 hours of becoming aware of the incident effecting 1 of 1 former clients (FC #4). The findings are:

Record review on 3/6/19 for FC #4 revealed:
- Admitted on 11/15/18 with diagnoses of Oppositional Defiance Disorder, Post-Traumatic Stress Disorder, Major Depression, and moderate Intellectual Disability.
- Discharged 2/7/19.
- Age 14.

Interview on 3/15/19 with a dispatcher for the local Sheriff’s Department revealed:
- 11/24/18 elopement of FC #4, called in at 3:04PM. FC #4 returned to the facility at 6:24PM. He was picked up in a neighboring county approximately 2 miles away.
- 1/6/19 elopement of FC #4 called in at 4:08PM. FC #4 was returned at 4:30PM. No location identified.
- 1/7/19 elopement of FC #4 called in at 6:12PM. No return time or location of pick up identified.
- 1/13/19 disturbance at the facility that involved FC #4. Police were on site.
- 1/14/19 elopement of FC #4 called in at 11:51AM. No return time or location of pick up identified.
- 1/20/19 elopement of FC #4 called in at 4:48PM. FC #4 returned to the facility at 5:31PM. He had been picked up near the local bypass approximately 3 miles away.
- 1/21/19 report of van keys missing. Police on site.
- 1/28/19 report of possible drug use. Police on site. No person identified.
- 2/5/19 elopement of FC #4 called in at 6:33PM. FC #4 was returned at 7:18PM. No location identified.
**V 367** Continued From page 36

-2/6/19 elopement of FC #4 called in at 7:28PM. He was returned at 9:27PM. He was picked up approximately three quarters of a mile away.

Review on 3/6/19 of facility incident reports and review on 3/15/19 of Level II incident reports submitted into the Incident Response Improvement System (IRIS) revealed:
- Level I incident reports not completed for all the dates the police were on site.
- Level II incident reports were only completed for 1/6/19 and 1/8/19. All other dates that police were on site there were no level II incident reports submitted into IRIS.

Interview on 3/19/19 with the Qualified Professional revealed:
- Staff reported incidents to her and she submitted into IRIS.
- She was not sure why IRIS reports not completed for the incidents.
- Service notes were completed but IRIS reports were not done. She stated she needed to improve how they did incident reports.

**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; 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 1 of 1 former clients (FC #4). The findings are:

Record review on 3/6/19 for FC #4 revealed:
- Admitted on 11/15/18 with diagnoses of Oppositional Defiance Disorder, Post-Traumatic Stress Disorder, Major Depression, and moderate Intellectual Disability.
- Discharged 2/7/19.
- Age 14.

Review on 3/11/19 of the daily service notes for FC #4 revealed:
- On 1/7/19 "...staff reminded consumer of searching him before he arrives at the facility due to having suspicion of drugs and cell phone ..." Signed by the Director/Qualified Professional (Director/QP).
- On 1/7/19 3:00PM-9:00PM "...Staff greeted consumer upon arrival and processed with the consumer about him having contraband on his person. Staff calmly explained to the consumer that he has turn over all of the contraband before
A. BUILDING: ____________________________ 
B. WING _____________________________ 

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

- 103 EBENEZER ROAD
- KINGS MOUNTAIN, NC  28086

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

- 103 EBENEZER ROAD
- KINGS MOUNTAIN, NC  28086

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

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he enters the facility to ensure the safety of others as well as himself ... staff eventually got the consumer to give up a few items of contraband. Staff called the local authorities to ensure that the consumer did not have anymore items "-On 1/14/19 " ... Staff informed the consumer that he needed to give up his foreign objects as well as contraband before he is able to enter the facility "

Interview on 3/13/19 with FC #4 revealed: 
- He was searched every day. He had to show staff what was in his pockets. The staff padded his shoulders. 
- Sometimes he did not agree to be searched and ran away.

Interview on 3/7/19 with Staff #1 revealed: 
- FC #4 was asked to empty his pockets. The police would do body searches if needed. 
- Two staff would conduct room searches 
- They did not always document search and seizure.

Interview on 3/7/19 with the House Manager revealed: 
- Searches involved having the client empty all their pockets. They did not put hands on the clients. 
- FC #4 started bringing in contraband and that's why they started search and seizure. 
- They never really did any searches before FC #4 was admitted. 
- Now they routinely search any clients from the alternative school. All pockets are emptied. 
- They had never documented the searches and he was not aware of the requirement.

Interview on 3/19/19 with the Qualified Professional revealed:
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- She was unaware of the required information that needed to be documented for search and seizure.
- Search and seizure was done whenever suspicious of contraband.
- FC #4 was searched regularly due to bringing in contraband from school.
- The need for search and seizure was explained to his guardian.
- Staff would have clients empty pockets and remove shoes and collect any contraband found.