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	MHL0601400	A. BUILDING: _____ B. WING _____	08/16/2019

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V 000	INITIAL COMMENTS An annual survey was completed on August 16, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
V 106	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for facility areas including special client activity areas; and (18) client grievance policy, including procedures	V 106		

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V 106	Continued From page 1 for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to implement their written policy for services of volunteers. The findings are: Review on 8/14/19 of the facility's Guidelines for Group Volunteers revealed: -" ...Every volunteer must fill out and sign a volunteer Profile Form. In order to protect the safety and privacy of our children, any information about the children in our care, including names, is strictly confidential ..." Review on 8/14/19 of the Volunteer Profile Form updated 5/10/19 revealed: -The form included request for demographic information, volunteer activity, groups participating with, emergency contact, and confidentiality agreement and photo permission agreement with necessary signature. Attempted review on 8/14/19 of the Volunteer Profile Forms for the 7/13/19 volunteers were unsuccessful as no forms were ever completed and submitted to the facility. Interview on 8/14/19 with the Registered Nurse revealed: -A team of volunteers arrived at the facility on 7/13/19 and needed access to the yard via the locked gate;	V 106		

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V 106	Continued From page 2 Interview on 8/13/19 and 8/14/19 with the Qualified Professional #1/Program Supervisor revealed: -Was aware that the volunteers would be at the facility on 7/13/19. Interview on 8/14/19 with the Volunteer Coordinator revealed: -The volunteers working at the facility on 7/13/19 were a team of Boy Scouts and adult chaperones; -The volunteers were at the facility to create a Koi pond, garden boxes, and hang hammocks; -The vetting process is for the Volunteer Coordinator to ask the volunteer's potential interest, invite the volunteer for a tour. The tour and informal interview provides the Volunteer Coordinator the chance to assess the appropriateness of the volunteer opportunity; -There are no completed Volunteer Profile Forms on the Boy Scouts or adult chaperones from 7/13/19 visit; -The Eagle Scout Candidate from the Boy Scouts (identified only by first name) did not submit the completed Volunteer Profile Forms from the 7/13/19 visit. Interview on 8/15/19 with the Chief Operating Officer revealed: -Would make sure all Volunteer Profile Forms were on file at the facility in the future.	V 106		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals.	V 109		

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V 109	Continued From page 3 (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 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 interview and record review, 1 of 2 audited Qualified Professionals (Qualified Professional #1/Program Supervisor) failed to display the knowledge, skills, and abilities of the population served. The findings are:	V 109		

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V 109	Continued From page 4 Review on 8/13/19 of the Qualified Professional #1/Program Supervisor's (QP#1/PS) record revealed: -Hired 12/3/18. Review on 8/13/19 of the facility's Incident Reports revealed: -Level II incident report dated 7/13/19 involving Client #1's AWOL (absence without leave) after the Registered Nurse (RN) left the facility gate unlocked. Interview on 8/16/19 with Staff #10 revealed: -Had only been working for a few weeks when Client #1 went AWOL on 7/13/19; -Was in the fenced yard with Client #1 when it started to rain on 7/13/19; -Client #1 pushed at the gate and was able to get out of the fenced yard; -Staff #10 was securing a ladder left by a team of volunteers when Client #1 was able to open the gate; -Was not sure if the gate was locked or unlocked but assumed it was unlocked. Interview on 8/14/19 with the RN revealed: -A team of volunteers arrived at the facility on 7/13/19 and needed access to the yard via the locked gate; -Only the QP#1/PS and the Maintenance Supervisor (MS) had the code to unlock the gate; -The RN called the QP#1/PS as both the QP#1/PS and the MS were off work; -The RN was given the code over the phone by the QP#1/PS and instructed to unlock the gate to allow the volunteers access to the yard; -The QP#1/PS instructed the RN to "lose the code" to the gate after unlocking and re-locking the gate;	V 109		

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V 109	Continued From page 5 -The gate was opened on 7/13/19 to allow access to a team of Boy Scouts and adult volunteers completing landscaping work at the facility; -The RN closed the gate and believed she adequately locked the gate by rolling the numbers on the gate lock and pushing against the gate to ensure that gate would not open after the volunteers finished for the day on 7/13/19; -The RN had never received training on how to properly secure the gate lock; -Opening and closing the yard gate was not a direct job responsibility for the RN; -Client #1 was agitated and requested to go for a walk with Staff #10 after the volunteers had left on 7/13/19; -Rain was expected so Staff #10 did not want to take Client #1 for a walk due to the pending weather. Staff #10 accompanied Client #1 out to the yard. The gate door was closed. -When it started to rain, the RN checked on Staff #10 and Client #1 who were outside and Client #1 was forcefully shaking the gate door and the gate door opened and Client #1 went AWOL; -The RN sought assistance from additional staff; -Client #1 was able to travel approximately ½ mile and was returned to the facility by law enforcement; -The volunteers arrived at the facility on another day after the 7/13/19 incident again without arrangements for how they would access the facility yard, but the RN refused to assist them with the gate lock. Interview on 8/13/19 and 8/14/19 with the QP#1/PS revealed: -Client #1 went AWOL on 7/13/19 when the RN left the gate open; -Only three individuals had the gate code to open the gate to the facility yard: QP#1/PS, maintenance, and food service;	V 109		

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V 109	Continued From page 6 -The RN was given the code over the phone and instructed to open the gate and allow the volunteers to enter the facility yard for landscaping purposes; -The RN was never trained on the proper use of the gate lock; -The QP#1/PS was aware that the volunteers would be at the facility on 7/13/19 but did not make arrangements for them to enter the facility yard. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
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	V 112		

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V 112	Continued From page 7 responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement strategies to address the functional needs of the clients affecting 1 of 2 audited current clients (Client #1) and 1 of 1 audited former client (Former Client #3). The findings are: Finding #1 Review on 8/14/19 of Former Client (FC) #3's record revealed: -Admission date 4/22/19; -Discharge date 6/13/19; -Diagnoses of Attention Deficit Hyperactivity Disorder, Mood Disorder, Conduct Disorder, Post-Traumatic Stress Disorder, Cannabis Use Disorder; -16 years old during treatment at the facility; -Psychiatric Evaluation dated 4/27/19 by the facility's Psychiatrist revealed the client had a history of witnessing domestic violence between biological parents, suicidal threats, verbal and physical altercations with her mother, physical abuse at the hands of her father, extensive episodes of running away (during which she would engage in unprotected sex and use marijuana and was sexually assaulted by an 18 year old when she was 13 years old), aggressive and defiant behaviors, traumatic memories of her	V 112		

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V 112	Continued From page 8	V 112		

father attacking girlfriends and wielding a knife, truancy from school, and possible human trafficking;
-Discharge Summary dated 6/28/19 revealed "Reason for Referral: [FC #3] was initially admitted to Thompson PRTF (Psychiatric Residential Treatment Facility) (Licensee) on 4/22/19 ...from detention. [FC #3]'s charges included felony of a motor vehicle, possession of a stolen motor vehicle, and reckless driving to endanger ...has a history of juvenile justice involvement that includes assault with a deadly weapon, stealing a vehicle and crashing into a home, and removing her ankle monitor 5 days after receiving it ...has a history of running away from home and from placements and being gone for months at a time ...defiant, noncompliant, verbally and physically aggressive behaviors, and risk-taking behaviors that put herself and others at risk..."
-Treatment Plan dated 5/17/19 included goals for mood regulation and coping skills (" ...develop the coping skills necessary for managing mood, behaviors and emotional reactions related to traumatic experiences and interpersonal stressors ..."), communication and conflict resolution (" ...learn to express negative emotions and needs in a healthy manner as evidenced by increasing her ability to accurately identify her feelings and triggers, and by communicating her feelings and needs in an assertive and nonaggressive manner ..."), noncompliance and defiance (" ...cooperate with rules and expectation of the program and during home visits as evidenced by accepting the word 'no' and accepting limits without arguing, threatening others, or becoming disrespectful or verbally aggressive ..."), impulsivity (" ...develop the skills necessary to manage impulses that lead to poor decision and negative outcomes ..."), and

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V 112	Continued From page 9	V 112		

program engagement (" ...will engage in the program and abide by program rules and expectations as evidenced by engaging in weekly individual therapy sessions, engaging in weekly group sessions, engaging in family sessions, engaging in scheduled program activities ..."). Treatment strategies were: " ...[FC #3] will participate in individual and group therapy, participate in family therapy, report triggers to therapist during individual and group therapy, identify and practice coping skills on the milieu and during therapeutic leave. PRTF will provide a safe environment for [FC #3] to engage in therapy, provide individual, group and family therapy, encourage [FC #3] to utilize coping skills ...;"
-Upon admission to the facility, there was a documented history of AWOL, stealing motor vehicles and crashing into a home; however, there were no initial treatment strategies developed to address these behaviors;
-There were no follow up treatment strategies developed to address AWOL when FC #3 went AWOL on 5/24/19 while on a medical appointment;
-There were no follow up treatment strategies developed to address stealing a motor vehicle and going AWOL when FC #3 took the van keys, stole the company van, and went AWOL on 5/28/19;
-There were no additional treatment strategies developed when FC #3 went AWOL on 6/13/19 after a court appearance to answer a summons regarding taking the keys to the company van and stealing the van. FC #3 was never recovered after the 6/13/19 incident and was subsequently discharged on that date.

Review on 8/13/19 of the facility's Incident

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V 112	Continued From page 10 Reports revealed: -Level II incident report dated 5/24/19 involving FC #3's AWOL while on a medical appointment; -Level II incident report dated 5/28/19 involving FC #3's AWOL from the facility after stealing the keys to the company van. FC #3 absconded in the van and was detained by law enforcement. -Level II incident report dated 6/13/19 involving FC #3's AWOL after a court appearance answering a summons regarding taking the keys to the company van and stealing the van. Review on 8/14/19 of a memo sent by the Qualified Professional #1/Program Supervisor (QP#1/PS) to Staff #4, #6, and #7 dated 5/30/19 with offense date of 5/28/19 revealed: -"Supervisor provided coaching to staff regarding maintaining appropriate line of sight and proximity to clients at all times and ensuring that if a client moves into another room that the staff is to follow right behind providing verbal prompts. We reviewed appropriate positioning and where staff should be located in each area of the cottage. This was in response to a client taking our van keys from the nursing desk and absconding through a window in the therapist office and taking the vehicle." Attempted review on 8/13/19, 8/14/19, and 8/15/19 of the vehicle key storage protocol was unsuccessful. After repeated requests, no protocol was produced. The Quality Assurance Specialists revealed that there was no protocol after review of the Policy and Procedure Manual. Unable to interview FC #3 because FC #3 went AWOL on 6/13/19 and was never located. Interview on 8/13/19 with Staff #4 revealed:	V 112		

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V 112	Continued From page 11 -Worked when FC #3 took the van keys and stole the van; -FC #3 took the van keys out of the desk drawer in the common area of the facility; -The windows in the facility were alarmed and the alarm sounded when FC #3 opened the window; -FC #3 drove to the highway where she was arrested by law enforcement (distance unknown). Interview on 8/13/19 with Staff #5 revealed: -Worked when FC #3 took the van keys, went out the window, and stole the van; -Law enforcement stopped FC #3 approximately 4-5 miles from the facility, secured the van, and arrested the client; -FC #3 had previous criminal charges for stealing a vehicle. Interview on 8/15/19 with Staff #6 revealed: -Worked when FC #3 took the van key, went AWOL, and stole the van on 5/28/19; -Was in the kitchen of the facility when the keys were taken; -The van keys were stored in an unlocked desk drawer in a notebook; -The desk drawer was supposed to be locked; -Not sure why the desk drawer was unlocked on 5/28/19; Interview on 8/15/19 with Staff #7 revealed: -Was completing training at the facility on 5/28/19 but left work prior to FC #3 taking the van keys and stealing the van. Interview on 8/16/19 with Staff #8 revealed: -Was not working when FC #3 took the van keys and stole the van; -The van keys were stored in the desk drawer and the desk drawer should have been locked but not sure what happened on 5/28/19.	V 112		

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V 112	Continued From page 12 Interview on 8/15/19 with Staff #9 revealed: -Did not work when FC #3 took the van keys and stole the van; -The van keys had been stored in the drawer of the living room desk; -The desk was not locked. Interview on 8/13/19 and 8/14/19 with the QP#1/PS revealed: -FC #3 was admitted with a history of stealing vehicles and had been on probation for stealing a car and crashing the car around a tree; -FC #3 went AWOL on 5/24/19 from the dentist, 5/28/19 after taking the keys to the van and stealing the van, and 6/13/19 after a court appearance; -Due to FC #3's AWOL history, FC #3 was accompanied by the QP#1/PS, two direct care staff members, the Department of Juvenile Justice caseworker, and FC #3's legal guardian/mother; -FC #3 went AWOL on 6/13/19 from the courthouse and was never located. Interview on 8/15/19 with the Vice President of Clinical Operations revealed: -FC #3's treatment plan included a goal to manage impulses that lead to poor decision and negative outcomes which addressed any decisions to take the van keys and steal the van. Interview on 8/15/19 with the Chief Operations Officer revealed: -There was a protocol in place for safe storage of the vehicle keys and the staff did not follow the protocol and received disciplinary action from the QP#1/PS; -After the 5/28/19 incident, the keys to the vehicles were stored with the Receptionist in the	V 112		

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V 112	Continued From page 13 Administrative Offices during the week and the Nursing Station of the upper campus on the weekends. Staff were responsible for signing the keys out with the respective staff member. The vehicles were parked in a separate location. Finding #2 Review on 8/14/19 of Client #1's record revealed: -Admission date 6/17/19; -Diagnosed with Major Depressive Disorder, Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder; -15 years old; -Psychiatric Evaluation dated 6/17/19 by the facility's Psychiatrist revealed a history of "aggressive behaviors, verbal and physical aggression, suicidal threats, self-harm, running away, auditory hallucinations, physical aggression toward superiors, multiple emergency room visits," and poor regulation of emotions surrounding past physical and sexual abuse; -Treatment Plan dated 7/23/19 did not include treatment strategies to address absence without leave (AWOL); -Treatment Plan dated 7/23/19 included update of 7/23/19: "7/13/19-The gate to the yard was left open by a nurse, client saw the opportunity to leave, client left campus and went up to [main road]. Staff was concerned about her safety; client was found within fifteen (15) minutes by police. Client kicked the police and was escorted back into the facility. Client just completed two (2) weeks of elopement protocol;" -There was a documented history of AWOL upon admission to the facility, but no initial treatment strategies were developed to address AWOL; -There were no follow up treatment strategies developed to address AWOL when Client #1 went	V 112		

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	MHL0601400	A. BUILDING: _____ B. WING _____	08/16/2019

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V 112	Continued From page 14 AWOL on 7/13/19 even though the treatment team convened on 7/23/19 (10 days after the AWOL). Review on 8/13/19 of the facility's Incident Reports revealed: -Level II incident report dated 7/13/19 involving Client #1's AWOL after the Registered Nurse (RN) left the facility gate unlocked. Interview on 8/14/19 with Client #1 revealed: -Could not remember details about running away on 7/13/19. Interview on 8/16/19 with Staff #8 revealed: -Worked when Client #1 went AWOL on 7/13/19; -Was downstairs with other clients when Client #1 went AWOL. Interview on 8/15/19 with Staff #9 revealed: -Was engaged in an activity with other clients when Client #1 went AWOL through the unlocked gate on 7/13/19; -Staff #10 was outside in the yard with Client #1 just prior to Client #1 going AWOL on 7/13/19; -Staff #10 texted Staff #9 and the RN for assistance when Client #1 went AWOL through the unlocked gate. Interview on 8/16/19 with Staff #10 revealed: -Had only been working for a few weeks when Client #1 went AWOL on 7/13/19; -Was in the fenced yard with Client #1 when it started to rain on 7/13/19; -Client #1 pushed at the gate and was able to get out of the fenced yard; -Staff #10 was securing a ladder left by a team of volunteers when Client #1 was able to open the	V 112		

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V 112	Continued From page 15	V 112		

gate;
-Was not sure if the gate was locked or unlocked but assumed it was unlocked.

Interview on 8/14/19 with the RN revealed:
-A team of volunteers arrived at the facility on 7/13/19 and needed access to the yard via the locked gate;
-Only the QP#1/PS and the Maintenance Supervisor (MS) had the code to unlock the gate;
-The RN called the QP#1/PS as both the QP#1/PS and the MS were off work;
-The RN was given the code over the phone by the QP#1/PS and instructed to unlock the gate to allow the volunteers access to the yard;
-The QP#1/PS instructed the RN to "lose the code" to the gate after unlocking and re-locking the gate;
-The gate was opened on 7/13/19 to allow access to a team of Boy Scouts and adult volunteers completing landscaping work at the facility;
-The RN closed the gate and believed she adequately locked the gate by rolling the numbers on the gate lock and pushing against the gate to ensure that gate would not open after the volunteers finished for the day on 7/13/19;
-The RN had never received training on how to properly secure the gate lock;
-Opening and closing the yard gate was not a direct job responsibility for the RN;
-Client #1 was agitated and requested to go for a walk with Staff #10 after the volunteers had left on 7/13/19;
-Rain was expected so Staff #10 did not want to take Client #1 for a walk due to the pending weather, so Staff #10 allowed Client #1 to spend time in the yard with Staff #10. The gate door was closed.
-When it started to rain, the RN checked on Staff #10 and Client #1 who were outside and Client #1

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V 112	Continued From page 16 was forcefully shaking the gate door and the gate door opened and Client #1 went AWOL; -The RN sought assistance from additional staff; -Client #1 was able to travel approximately ½ mile and was returned to the facility by law enforcement; -The volunteers arrived at the facility on another day after the 7/13/19 incident again without arrangements for how they would access the facility yard, but the RN refused to assist them with the gate lock; -After the 7/13/19 incident, the RN was not comfortable with the position she was placed in by the facility. Interview on 8/13/19 and 8/14/19 with the QP#1/PS revealed: -Client #1 went AWOL on 7/13/19 when the RN left the gate open; -The RN was given the code over the phone and instructed to open the gate and allow the volunteers to enter the facility yard for landscaping purposes; -The RN was never trained on the proper use of the gate lock; -The QP#1/PS was aware that the volunteers would be at the facility on 7/13/19 but did not make arrangements for them to enter the facility yard. Interview on 8/15/19 with the Vice President of Clinical Operations revealed: -The RN was upset regarding the interview and the discussion with the Division of Health Service Regulation survey staff on 8/14/19 and chose to resign from the facility. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23	V 112		

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V 112	Continued From page 17 days.	V 112		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1,	V 314		

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V 314	Continued From page 18 Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to address the functional deficits of the adolescents affecting 1 of 2 audited current clients (Client #1) and 1 of 1 audited former client (Former Client #3). The findings are: CROSS REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on interview and record review, 1 of 2 audited Qualified Professionals (Qualified Professional #1/Program Supervisor) failed to display the knowledge, skills, and abilities of the population served. CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on interview and record review, the facility failed to develop and implement strategies to address the functional need of the clients affecting 1 of 2 audited current clients (Client #1) and 1 of 1 audited former client (Former Client #3). Review on 8/16/19 of the Plan of Protection dated 8/15/19 written by the Chief Performance and Quality Officer revealed:	V 314		

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V 314	Continued From page 19 "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? 10A NCAC 27G .0203: Competencies of Qualified Professionals and Associate Professionals (V109) -Direct care staff will be retrained on AWOL (Absence Without Leave) Precautions Strategies on 8.15.19-8.16.19. This will be facilitated by [Vice President of Clinical Operations]. -Individual coaching will be provided to The Smith (facility) Program Supervisor (Qualified Professional #1/Program Supervisor) on 8.16.19. This will be facilitated by [Vice President of Clinical Operations]. 10A NCAC 27G .025 Assessment and Treatment/habilitation of Service Plan (v112): cross referenced to 10 A NCCAC 27G. 1901 Scope (V314 -Client 1 (Former Client #3) is now discharged -Client 2 (Client #1)-Updated interventions and strategies to address recent AWOL incident will be updated by the next CFT (Child Family Team). -All Smith Cottage (facility) residents' clinical/behavioral histories will be reviewed for AWOL risk, and treatment plans will be updated to reflect strategies. This will be completed by 8.30.19. -This will be facilitated by [Psychiatric Residential Treatment Facility (PRTF) Clinical Director]. -For clients whose treatment plans that are updated/revised based on this review, retraining will occur for all direct care staff related to those client-specific issues/strategies. This will be completed by 8.30.19. Describe your plan to make sure the above happens. [Vice President of Clinical Operations] will meet with PRTF leadership team on 8/16/19 to confirm	V 314		

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V 314	Continued From page 20 that immediate actions steps listed were taken." Client #1 was 15 years old and had diagnoses of Depression, PTSD, and ADHD. She also had a history of verbal and physical aggression, suicidal threats & self-harm, running away, auditory hallucinations, poor regulation of emotions related to past physical and sexual abuse and multiple emergency room visits. There were no treatment strategies in place to address absence without leave (AWOL) behaviors. Client #1 was able to run away through an unlocked gate on 7/13/19. A treatment plan updated 7/23/19 did not contain any strategies related to the AWOL. Former Client #3 was 16 years old and had diagnoses of ADHD, Conduct Disorder, PTSD, and Cannabis use. She had a history of suicidal threats, aggressive and defiant behaviors, truancy from school, possible human trafficking, and extensive episodes of running away. Incidents that occurred during AWOLs included unprotected sex, sexual assault by an 18 y.o, stealing a vehicle, and assault with a deadly weapon. There were no treatment strategies in place to address AWOL or stealing vehicles. Former Client #3 was able to run away from a medical appointment on 5/24/19, stole keys to the company van and went AWOL on 5/28/19, and ran from a court appearance 6/13/19. No additional treatment strategies were put in place after the AWOL on 5/24/19 or the AWOL on 5/28/19. She has not been located since the 6/13/19 AWOL. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 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.	V 314		