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V 000	INITIAL COMMENTS A complaint survey was completed on January 6, 2021. The complaints were substantiated (Intake #NC00169070, NC00170213 and NC00171613). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services for Individuals of all Disability Groups.	V 000		
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. (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	V 109		

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V 109	Continued From page 1 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, the facility failed to ensure the Respite Center Manager/Qualified Professional (QP) demonstrated knowledge, skills and abilities for the population served for 1 of 1 QP. The findings are: Refer to V110 for additional information. Review on 1/6/21 of the Respite Center Manager/QP's employee record revealed -she was hired 1/11/16. -she worked Monday through Friday, 8:00 a.m. to 5:00 p.m. Review on 1/6/21 of the Respite Center Manager/QP's job position, duties and responsibilities revealed: -it was signed 4/17/19. -staff was responsible for management of the facility 24-hours, 7 days a week and involved the supervision of direct support staff. Interview on 11/18/20 with the Respite Center Manager/QP revealed:	V 109		

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V 109	Continued From page 2 -she was covering as a Residential Coach on 11/10/20 due to the assigned staff member being in training. -her shift partner on this day was Staff #1. This deficiency is cross referenced into 10A NCAC 27G.0208 Client Services (V115) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 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 develop and implement policies and procedures	V 110		

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V 110	Continued From page 3 for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on interviews and record reviews, one of one paraprofessional (Staff #1) failed to demonstrate competence in adhering to the facility protocol to keep eyes on clients at all times affecting 4 of 7 Former Clients (FC) audited (FC #8, FC #12, FC#13, and FC #14). The findings are: Review on 12/1/20 of the job description for paraprofessionals as Residential Coach (undated) revealed: -"Roles and Responsibilities:...Provide direct supervision of clients at all times which includes eyes on, line of sight, and in distance of hearing supervision..." Review on 11/23/20 and 12/1/20 of Staff #1's employee record revealed: -hired 11/19/18 as a Residential Coach. -7/6/20 Supervision note - inappropriate personal and professional boundaries with co-workers and clients. -7/23/20- Performance Improvement Plan - 1st warning - unprofessional behavior - poor professional boundaries with clients - using personal money to buy items for clients. -8/19/20 - Performance Improvement Plan - 2nd warning - on 8/17/20 supervisor notified by client's guardian the client (FC #8) had been utilizing the staff's personal cell phone to access	V 110		

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V 110	Continued From page 4 social media. -11/17/20 - Performance Improvement Plan - final warning - unprofessional behavior - on 11/11/20 supervisor was notified the staff had been following a client who had ran away on social media. She had been posting publicly trying to reach out to the client (FC #12). -staff intentionally withheld information about the client's ideation that impeded their ability to monitor clients. -11/17/20 - Supervision note - staff said she did not say anything about the clients wanting to run away because they said they were joking or venting. She did not think it was serious. Review on 12/3/20 of Group Supervision Notes from July 2020 through November 2020 held by the Respite Center Manager/QP with all staff revealed: -7/16/20 -discussed "eyes on" supervision of clients, professional boundaries between staff and clients, and "...transference of emotions to clients was not role-modeling healthy relationships." Staff should not utilize personal funds to buy things for clients, and should not give gifts to clients. This was an unethical practice and an inappropriate boundary. Human Resources Director and Child Services Director discussed professional boundaries and potential disciplinary actions for not following through on expectations. -8/19/20 - discussed "eyes on" supervision with clients. Addressed lack of accountability - "...if see their shift partner violating policies or displaying poor boundaries and they choose not to say anything, they are being complacent in making the house an unsafe environment for staff and clients...Child Services Director emphasized the need for staff to have accountability and appropriate boundaries with the clients, and that	V 110		

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the clients were not their children..." A staff member asked for clarification on boundary violations. The example of "...allowing clients to go upstairs together without staff observing..." was given. Addressed allowing clients to get hold of their personal cell phone and get on social media.
-9/29/20 - provided "...feedback on the reliance on technology and the need for increased supervision..." Discussed the incident on 9/16/20 when clients (FC #13 and FC #14) triggered the alarms by opening and shutting their bedroom doors and meeting in the bathroom. The expectation of one staff remaining upstairs while the clients were in their rooms was set in place. Examples were provided "...of times that clients in other facilities had been sneaky and had died, and cited these examples of the reason that eyes on supervision was necessary. The staff felt "...have to split up and stay upstairs with clients all night made for a very long shift, and that they were unable to hear the doors open and shut. They stated that they relied on the security system downstairs that said whether doors were open or shut..." Chief Operating Officer and Child Services Director discussed the need for professional boundaries.
-10/27/20- "...updated the team that once the new cameras were installed and operational, then their expectations would change to one staff walking clients upstairs and making sure doors were closed. Continue randomized room checks every 30 minutes."
-11/19/20 - "...feedback to staff on the need to monitor client computers...Update on the process of implementing the corrective plan of action after the client runaway incident. "...Child Services Director discussed how the client had used her school email to create an Instagram and another email account and that the client had contacted

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her ex-boyfriend to come and get her...emphasized the need for staff to be monitoring computer usage through eyes on contact..." The IT department will be setting up "...a filter that blocked clients from accessing social media, but that depending on the type of filter it would also block social media on staff phones as well...." Addressed complaints from night shift and that "...social media was not necessary to complete their job and that they should be focusing on their other responsibilities."

Review on 12/9/20 of the undated "Care Haven House Rules" for clients revealed:
-"1. Check with staff before going upstairs or outside.
-2. No cell phone allowed ...
-3. All other electronics such as video games, iPods/MP3, etc will be up to staff discretion as far as use ...All electronics will be locked up at night and returned to the client the following morning ...WI-FI will not be accessible to clients ...
12. ROOMS UP means everyone must go to their room and wait calmly/patiently until the reason the ROOMS UP has been resolved ...."

Finding #1:
Review on 10/27/20 and 11/20/20 of FC #8's record revealed:
-16 years old
-diagnoses of Major Depressive Disorder, recurrent, severe, with anxious distress, Post-Traumatic Stress Disorder, Unspecified disruptive, impulse-control and conduct Disorder, Personal history of psychological abuse and neglect in childhood, and Disruption of family by separation or divorce.
-admitted 5/23/20
-discharged 8/20/20

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V 110	Continued From page 7 Review on 10/27/20 and 11/20/20 of FC #8's Person-Centered Plan (PCP) with an original date of 6/16/20 and last updated 7/20/20 revealed: -6/16/20 - the client just found out her phone was sent to the police when it was discovered she sent inappropriate pictures to a male she met on-line. -goal - respite - "[FC #8] will work to maintain her safety while receiving respite care services...staff will provide periodic support and relief to primary caregiver...[FC #8] is in need of periodic breaks from her family for her overall wellbeing...." -objectives: client "...will be receptive to receiving respite care services...will be able to remain safe and healthy in a variety of settings...will be able to demonstrate age/developmentally appropriate daily living skills in her respite home environment and during community activities while receiving respite care services. -7/20/20 - client continues to benefit from respite services. Interview on 11/23/20 with FC #8's Guardian revealed: -the family found out from a mutual friend's daughter the client had been on social media. -he viewed the "near naked photos" the client sent to "approximately 50 boys" while she was at the facility. -he did not have the photos in his possession but documented the dates as 7/21/20, 7/23/20, 7/28/20, and 8/2/20 when the photos were posted. -he felt since there were so many "texts and snaps" to just one boy over this four-day time frame the client had access to a phone or other electronic device more than one time. -the client had also been accessing her school account and talking to friends while at the facility.	V 110		

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V 110	Continued From page 8 Interview was attempted on 11/23/20 with FC #8: - the client's guardian refused due to her progression in her current placement. Interviews on 10/13/20 with Clients #2 and #3 revealed: -social media was blocked on the school computers but it could be accessed on the facility's computer. -they knew of a previous client who was able to get on Facebook while on the facility computer. -the facility computer had been used in the staff office while staff were in the dining room - they used it to talk with therapist and watched a movie. -the staff watched what they were doing while at the dining room table, but when they walked away social media could be accessed - she wouldn't do this though since staff could check the history of what was accessed. -staff cell phones were left on the table if they didn't have pockets to put them in. Interview on 12/1/20 with Staff #1 revealed: -around the latter part of August 2020 FC #8 came to her and said she needed to tell her something. -FC #8 confessed she took her personal cell phone that was laying on the table to the bathroom and got on social media. -she felt the client could not have had her phone long as she did not notice it was missing. -the only reason she knew the client took it was because the client felt bad and told her. -this was the only time she was aware of the client taking her phone. -since then the staff were required to have phones on them at all times. -when clients did not have a lap top from their school, they used one of the two facility lap tops. -they were working on getting a filter put on the	V 110		

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facility laptops so that social media would be blocked.
-all the clients sat at the kitchen table to do their school work.
-staff sat with them at the table and took turns walking around the table to ensure no inappropriate content and social media was being accessed on the internet.

Interview on 12/2/20 with Staff #2 revealed:
-she was not aware of FC #8 being on social media.
-when clients were on their computers for school staff would sit between them and watch what they were accessing.
-the supervision requirements were to maintain eyes on the clients unless they were in their bedrooms or in the bathroom.
-this level of supervision was the same for all clients regardless of their history.

Interview on 12/3/20 with Staff #3 revealed:
-he knew FC #8 accessed social media after the fact.
-when the clients were on their computers staff took turns walking around the table to ensure they were doing their school work.
-there was no social media they could access on the computers, but " ...they have snuck around that before ...."
-in the summer they would let the clients have the computers " ...for music and what not ..."
-they would have " ...to be very crafty..." to access social media, " ...not saying they can't do it, but they would have to work hard at it ..."
-the supervision requirements were to keep eyes on the clients at all times.

Finding #2:
Review on 12/15/20 and 12/17/20 of FC #13's

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record revealed:
-16 years old.
-diagnoses of Major Depressive Disorder, recurrent episode, moderate and Post-Traumatic Stress Disorder.
-admitted 9/8/20.
-discharged 9/18/20.

Review on 12/17/20 of FC #13's Comprehensive Clinical Assessment (CCA) dated 8/20/20 revealed:
-admitted to acting impulsively at times when she felt " ...out of control ..."
-she had a history of seeking validation from older men and engaged in risky behavior while living with her family.
-she had an extensive history of being neglected, and physically and sexually abused.

Review on 12/17/20 of FC #14's record revealed:
-16 years old.
-diagnoses of Post-Traumatic Stress Disorder, Intellectual Developmental Disorder, mild, Attention-Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and Adjustment Disorder.
-admitted 9/4/20.
-discharged 9/17/20.

Review on 12/17/20 of FC #14's CCA addendum dated 1/15/20 revealed:
-history of sexual abuse.
-impulsive behavior, sleep disturbance and outbursts of anger.

Review on 12/17/20 of a level II facility incident report dated 9/16/20 revealed:
-inappropriate sexual behavior between FC #13 and FC #14.
-on 9/16/20 staff noticed a hickey on FC #14's

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neck.
-FC #14 reported that he and FC #13 conspired to meet in the bathroom upstairs during "room-ups."
-the clients reported they met on 3 or 4 occasions to " ...make out ..." and it was always during the 3:30 "room-ups."
-the accounts of how far they went sexually differed from kissing and fondling to oral sex and intercourse.
-the clients said they circumvented the alarm system by opening and closing their bedroom doors to make it seem like they walked out and walked back into their room.
-one client would wait in the bathroom until the other client came.

Interviews were attempted on 12/18/20 and 12/21/20 with FC #13 and FC #14's guardians:
-no returned calls were received.

Interview on 12/1/20 with Staff #1 revealed:
-the clients had two "room-ups" when they were required to be in their rooms for staff to have a 30-minute break.
-the first "room-up" was at approximately 3:00 p.m. - 3:30 p.m. and the second one around 5:45 p.m.
-she remembered hearing the alarm system saying, "room 2 door open", "room 5 door open" and thinking that was "odd" because of the way they opened.
-she and Staff #2 were in the living room at the time (did not remember exact date) but thought it " ...seemed funny how the door chimes kept going off ..."
-when she looked at the monitor of the security system all the bedroom doors were shut.
-we then heard the alarm system say FC #13's door opened.

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-she thought "I don't remember her [FC #13] getting out of the bathroom."
-she then went upstairs, and FC #14 was the only one walking out of the bathroom - so she didn't pay it any attention.
-a couple of days later was when she and Staff #2 noticed a hickey on FC #14's neck.
-since this incident every time the client's room-up they have a staff sitting upstairs as well.
-management was working on implementing stricter rules, doing more checks at night, holding staff more accountable.
-"Until something happens we don't know it's broke type of thing."

Interview on 12/2/20 with Staff #2 revealed:
-she had " ...absolutely no idea ..." FC #13 and FC #14 were circumventing the alarm system.
-there had always been chimes on the door that notified them when and what bedroom door opened.
-if she heard door chimes going off, she would walk upstairs to see what was going on.

Interview on 12/2/20 with Staff #3 revealed:
-"room-ups" were in the afternoon for about 30 minutes to catch up on notes and to give the clients a break.
-prior to this incident they just sent the clients up - now staff go upstairs with them and make sure they go to their rooms.
-then we monitor them on the tablet and listen for the alarm system if a bedroom door opened.
-FC #13 and FC #14 claimed they snuck into the bathroom while he was on shift, but he did not remember hearing any door alarms going off unusually.

Review on 12/17/20 of an undated "Level 3 Critical Incident Internal Review Summary"

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revealed:
-a summary of the incident between FC #13 and FC #14.
-a clarification of "Room Ups" - " ...where clients are separated into their room so staff can sanitize and/or complete documentation. Room ups are 30 minutes long, one occurs during the day shift and one occurs during the evening shift."
-"Issues Identified: Questions surrounding supervision, clients snuck around the system to engage in this activity, sensors on the door were triggered but clients figured out a work around to trigger the sensors to make it appear as though they had entered their respective room ..."
-"Recommendations for Minimizing the Occurrence of Future Incidents: Staff will be stationed upstairs during 'room up.' ...staff will be providing an additional check after clients have gone to room to verify locations of clients. Staff will provide visual, randomized, interval checks ...the agency is exploring the option of adding another camera to better view the bathroom entryway."

Finding #3:
Review on 11/19/20 and 11/20/20 of FC #12's record revealed:
-16 years old.
-diagnoses of Major Depressive Disorder, recurrent, moderate, Generalized Anxiety Disorder, and Unspecified Trauma and Stressor Related Disorder.
-admitted 10/20/20.
-absent without Leave (AWOL) 11/10/20.

Review on 11/19/20 and 11/20/20 of FC #12's Initial Referral form dated 10/16/20 revealed:
-symptom areas to be checked were for current and/or history.
-history symptoms checked were increased

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V 110	Continued From page 14 irritability, refusal to comply, trouble eating/sleeping and running away. Review on 11/20/20 of FC #12's CCA dated 8/5/20 and CCA addendum dated 10/20/20 revealed: -inappropriate sexual behavior - client tries to seek attention from any male who says "Hi, you are cute." -client stated she obsessed about guys and the way she looked; trauma - reckless behavior. -10/20/20 - client eloped from caregiver's home 10/6/20. Went to stay with her ex-boyfriend who she was in the process of filing a restraining order on - up to this point elopement had not been a major concern. Review on 11/20/20 of FC #12's PCP dated 8/11/20 and last revised 11/6/20 revealed: -Respite Care -client placed in respite due to concerns of her returning home due to elopement and self-harming behaviors. -client to work towards building coping skills and utilizing a de-escalation plan. -staff will provide periodic support and relief to the primary caregiver. -Inappropriate Sexualized Behavior- has been in the form of previous relationship with her 20-year old boyfriend and running away from her caregiver's home to be with the boyfriend. Review on 11/20/20 of staff Transition Notes from 11/7/20 through 11/9/20 revealed: -11/7/20 - client noticed to be more depressed than normal. Staff asked if wanted to share, she said she would talk about it later. Staff monitored to ensure she maintained proper boundaries with peers. -11/8/20 - client woke up early - was worried about going back to caregiver's house and her	V 110		

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V 110	Continued From page 15 sister. Seemed to feel better after talking about it. -11/9/20 - Staff #1 and the Respite Center Manager/QP talked with client about concerns of her comments of running away, self-harming and relationships. Client understood why they were concerned; she said she was making comments when she was upset and was just venting. Respite Center Manager/QP reminded client of house rules and consequences of her actions should she choose to take them. Review on 11/20/20 of a level III incident report dated 11/11/20 regarding FC #12 revealed: -the client ran away from the facility on 11/10/20 at 10:22 a.m. -" ...She left out the front door when staff had gone to get another client a pencil ..." -a peer informed staff the client ran away and got into a white car with a man in his early 20's. -later a letter was found written by the client stating she had contacted her ex-boyfriend and felt the restraining order against him was no longer needed. -the team suspected the client ran with the boyfriend and the reason they had not done this yet was because the boyfriend did not know where she was. -"Describe the cause of this incident ...Client ran away ..." -"Incident Prevention: ...This client has a history of running away from home. This client was able to sneak and access social media despite staff supervising school/agency computer usage ...Care Haven is seeking an internet filter to block and screen out all social media via Care Haven's Wi-Fi system." Review on 11/20/20 of a Level 3 "Critical Incident Internal Review Summary" dated 11/31/20 revealed:	V 110		

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-a summary of FC #12's AWOL as written in the incident report.
-"Issues Identified: Accessing social media and messaging sites on school computer and potentially on Care Haven Computer - request has been put in with IT to get a filter put in place to block social networking sites ...."
-"Recommendations for Minimizing the Occurrence of Future Incidents: Ensure entrance/exit to the house is closed and locked. Block social networking sites on Care Haven property ..."

Review on 12/15/20 of the facility video footage from 11/10/20 at approximately 10:32 a.m. of FC #12's AWOL revealed:
-a total of 48 seconds.
-FC #12 sitting in the dining room at one end of the table with Client #5 to her right.
-at approximately 00:004 seconds FC #12 looked up at the wall, put her back pack on her shoulder, and looked at Client #5.
-Client #6 was at the opposite end of the table with Staff #1 to his right.
-Staff #1's seat was facing the living room with her back to the kitchen; she was looking at her computer and her phone.
-at approximately 00:08 seconds the Respite Center Manager/QP was seen walking from the living room, into the dining room; FC #12 slowly took her back pack off her shoulder.
-the Respite Center Manager/QP continued walking through the dining room, past Client #6 and Staff #1, into the kitchen.
-at approximately 00:19 seconds FC #12 slowly stood up while looking at Client #5.
-at approximately 00:21 seconds, Client #5 started to close her lap top, but remained seated.
-at approximately 00:22 seconds FC #12 slowly started walking while putting her back pack on

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her shoulder and continued to look at Client #5.
-at approximately 00:23 seconds FC #12 was walking behind Client #5's seat, rounded the wall and walked into the living room.
-just as FC #12 rounded the wall into the living room, Staff #1 was seen looking up facing the entry way into the living room, toward the direction FC #12 just went; the back of FC #12 was in clear view at this time.
-at approximately 00:25 seconds, the Respite Center Manager/QP was seen walking from the kitchen, behind Staff #1, back into the dining room.
-at approximately 00:27 seconds the Respite Center Manager/QP walked behind Client #6's chair and turned her head to the right to look at the white board on the wall, behind where FC #12 was sitting.
-at this time on the top of the video screen a bright light was shining on the floor from the screen door being opened as FC #12 was walking out of it.
-at approximately 00:30 the Respite Center Manager/QP continued to walk toward the living room while she looked at the white board; just as she got to the entry way of the dining room and living room the front door closed at 00:31 seconds.
-the Respite Center Manager/QP turned her head and looked at Staff #1 who remained in her seat and they both put their arms in the air as if they were stretching.
-at approximately 00:38 seconds the Respite Center Manager/QP then turned toward the living room and walked back into it.
-at approximately 00:45 seconds Client #5 looked back and forth at the Respite Center Manager/QP who continued to walk into the living room and then looked at Staff #1 who continued to stay seated looking at her computer.

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V 110	Continued From page 18 Interview on 11/20/20 and 12/18/20 with FC #12's guardian revealed: -they were to have a Child Family Treatment (CFT) meeting on 11/10/20. -one of the CFT members texted her and asked if she had spoken to the facility. -she called the facility, and this was how she found out FC #12 went AWOL - about an hour and half later. -the Respite Center Manager/QP said there was a misunderstanding as she thought Staff #1 called her and notified her. -when asked how FC #12 got someone to pick her up, the Respite Center Manager/QP said she had accessed social media and emailed people. -when asked the Respite Center Manager/QP how this happened - she said "Honestly, [guardian's name] we can't tell you." -the Respite Center Manager/QP told her she got up to get a pencil and paper and then FC #12 was gone. -the client ran two times previous to coming to the facility once in June 2020 from her house, she tried to run from her grandmother's house but she was unsuccessful; the second time from her house in October 2020. -she requested a higher level of care than the respite facility, but the facility assured her the client would be safe as they had "cameras everywhere." -the client was located on 11/25/20 and was now in a Psychiatric Residential Treatment Facility (PRTF) and the Department of Social Services (DSS) had guardianship. Interview attempted with FC #12 on 12/18/20 and 12/22/20: -the local DSS who had guardianship refused for the client to be interviewed.	V 110		

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V 110	Continued From page 19 Interview on 11/18/20 with Client #5 revealed: -she was supposed to run with FC #12, but she just couldn't do it. -they whispered when making plans to run and staff would ask what we were talking about and we just said "Oh, nothing." -FC #12 said her stomach hurt and she was going upstairs to get her things. -she just got up and walked out the front door. -Staff #1 was sitting at table with clients, and the Respite Center Manager/QP was standing in the entry way between the kitchen and dining room. -she felt both staff should have heard the screen door shut. Interview on 11/18/20 with Client #6 revealed: -they were all siting at the dining room table doing school work. -he noticed FC #12 kept running back and forth upstairs saying she was going to get ready. -clients were not supposed to go upstairs without staff; and they had to ask if could go get what they were wanting. -he noticed FC #12 had her back pack with her which she never had it with her before. -he overheard FC #12 tell Client #5 to hurry up, go get ready, and hurry up. -when FC #12 walked out he felt staff should have heard the front door "slam" shut. -Client #5 kept saying "I can't do it. I just can't do it." -when Staff #1 realized what Client #5 was talking about FC #12 was already gone. Interview on 12/1/20 with Staff #1 who was working 11/10/20 when FC #12 went AWOL revealed: -she was sitting at the table next to Client #6 facing the living room entry way.	V 110		

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-now that she looked back, she could see little things that she didn't pick up at the time.
-FC #12 kept asking to go upstairs - one time to do morning routine, another time to take her back pack up, and another to use the restroom.
-she saw FC #12 grab her back pack and go into the living room.
-she thought the Respite Center Manager/QP was in the living room.
-then Client #5 looked at her, she was shaking and said, "I'm not going no where. I'm not going with her."
-she then thought "oh crap" FC #12 was gone.
-Client #5 said FC #12 got someone to come and pick her up.
-the Respite Center Manager/QP called the police and "rattled" off some names for her to call.
-she thought the Respite Center Manager/QP called FC #12's guardian, "it was a mistake."
-since this incident she now made sure the front screen door remained locked.

Interviews on 10/13/20, 11/18/20 and 12/2/20 with the Respite Center Manager/QP revealed:
-FC #8's family called and notified her the client had been accessing social media while at the facility.
-she was only aware of the one-time FC #8 stole Staff #1's cell phone off the kitchen table while the staff was cleaning.
-after becoming aware of this she gave additional training to all staff on standards of conduct to include personal boundaries.
-the level of supervision expectation was to have eyes on at all times and be within proximity of the clients.
-since the incident between FC #13 and FC #14 in September 2020 the staff now went upstairs with the clients during room-up and stayed there.
-they also added tablets so staff could view the

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upstairs while doing other tasks and could view the bedroom doors at any time.
-on 11/10/20 she was covering as a Residential Coach when FC #12 went AWOL.
-she remembered FC #12 asked Staff #1 if she could take her back pack up to her room.
-the client she was sitting with in the living room asked her if she would get a pencil and paper for him.
-she was either coming back from getting a pencil and paper, or she had just sat down in the living room after getting the pencil and paper and Client #5 said FC #12 was gone.
-she and Staff #1 spoke with FC #12 the day before she ran about making comments of running and the client said she was joking, venting and that she would not run.
-FC #12 had not attempted to run since being at the facility; she only knew of one time the client ran prior to her admission.
-after the fact she found out FC #12 had been able to set up another Gmail account while using the facility computer/lap top.
-FC #12 gave her boyfriend the address to the facility.
-prior to FC #12 running (she was not sure exactly when) she instructed day staff to be aware of FC #12's and Client #5's interactions and boundaries due to the underground behavior - " ...mainly they were baiting [Client #5], and be aware of the relationship and stay close by to enforce seating arrangements at the table.
-they already had alarms on the doors; bedroom and exterior doors chimed when opened and announced which door was opened/closed.
-they added a camera upstairs with a wide angle lens and now they could see the entire hall way; the clients bedroom doors and bathroom door were now in view.
- she instructed the night staff to walk upstairs

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and visually see clients go into their room and close the door; this started sometime in October, after surveyor's visit on 10/13/20.

Interview on 12/3/20 with the Compliance Officer and President Chief Executive Officer of the facility revealed:
-the job description of the paraprofessionals outlined the supervision expectations of clients.
-the house rules outlined the social media expectations.
-the staff were expected to be right there with the clients while on their computers.
-they were in the process of having their Information Technology (IT) department set up fire walls to block social media sites.
-they were not sure where IT was on getting this completed.
-staff were expected to be monitoring the live feed camera system when clients were out of sight.
-they also had additional administrative support staff that could feed into the cameras at any time and make observations of staff and client whereabouts.
-the Respite Center Manager/QP was to monitor the staff more frequently as well.
-to their knowledge the only staff person who viewed the video footage on 11/10/20 regarding FC #12 was the Respite Center Manager/QP.

Interview on 12/9/20 with the President Chief Executive Officer revealed:
-it was not that anyone didn't want to review the video footage from 11/10/20.
-it was more of a programmatic issue, there were barrier issues with their system, staff not being able to navigate it, and it was not that user friendly.
-she had IT assist her and had now reviewed the

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V 110	Continued From page 23 footage from FC #12's AWOL. -she did not like what she saw and saw the two staff sitting right there and one was facing FC #12. -she felt this was not acceptable. Review on 12/14/20 of an email from the President Chief Executive Officer regarding additional information surrounding the AWOL revealed: -after FC #12 walked out of the front door, the door did not shut completely and did not make a closing sound that would have alerted the staff. -Staff #1 reported FC #12 had asked her for permission to take her back pack upstairs right before the incident. This deficiency is cross referenced into 10A NCAC 27G.0208 Client Services (V115) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 110		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for	V 115		

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V 115	Continued From page 24 clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure supervision was provided to ensure the safety and welfare of the clients for 4 of 7 Former Clients (FC) audited (FC #8, FC #12, FC #13 and FC #14). The findings are: Cross Reference: 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on interview and record review, the facility failed to ensure the Respite Center Manager/Qualified Professional (QP) demonstrated knowledge, skills and abilities for the population served for 1 of 1 QP. Cross Reference: 10A NCAC 27G.0204 Competencies and Supervision of Paraprofessionals (V110). Based on interviews and record reviews, one of one paraprofessional (Staff #1) failed to demonstrate competence in adhering to the facility protocol to keep eyes on clients at all times affecting 4 of 7 Former Clients	V 115		

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V 115	Continued From page 25 (FC) audited (FC #8, FC #12, FC#13, and FC #14). Review on 1/5/21 of the Plan of Protection dated 1/5/21 written by the President Chief Executive Officer revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? See Strategic Planning Document titled QIP CARE HAVEN shared 1/05/21 at 8:20 P.M. Additional Notes: Training for Staff - Additional training is currently being scheduled (other than such noted on the QIP). Prior to the follow up visit please request and updated list of training requirements for staff of the Care Haven. Supervision: Additional supervision and staff presence will be made available for the facility. ACA [A Caring Alternative (licensee)] is adding a position for oversite of the facility in addition to the Care Haven Respite Manager. This position is called a Program Manager: Job description being developed (1/28/2021) - position will be in place by this date. ACA operational management have a candidate in mind to fulfill this position... Administrative Watch: A rotation of administrative staff will be assigned to perform administrative watch over the facility activities including monitoring of compliance to the Plan of Protection. The schedule is currently being developed (as of the date of this document 1/05/2021 at 8:39 P.M. The schedule will be finalized but likely after the time requested for the Plan of Protection (1/06/2021 at 9 A.M.) The schedule will assign leadership staff as follows: [staff names]. Describe your plans to make sure the above happens.	V 115		

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V 115	Continued From page 26 See Care Haven QIP Document. Additional measures will be added to the Administrative Watch responsibilities to include a compliance verification of the Protection Plan protocol. Review on 1/5/21 of page 2 of the Plan of Protection attachment dated 1/5/21 written by the President Chief Operations Officer revealed: "A Caring Alternative Quality Improvement Project Description Form Section 1 - Background Information Project Name: CARE Haven Content Area(s): X Dept./Service specific: CARE Haven Agency wide other Type of Project: X quality of service error reduction Customer Service other Project Description: Responding to high acuity client needs/behaviors Project Manager: [Staff names] Project Team Members: [Staff names] Implementation Start Date: December 21, 2020 Timetable for Implementation: Evaluation Completion Date: Section 2 - Project Basis: CARE Haven currently has an open investigation with DHHS *DHSR regarding staff training and supervision. Leadership is conducting a thorough review of staff training and supervision related to children being placed in our respite facility. Goal for Improvement: Intake/Admission Process Section 3 - Strategies Specify a detailed plan to improve performance, as follows: Strategic objective - What we will do.	V 115		

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V 115	Continued From page 27 Implementation measure - How we will know we've done it Implementation timeline - When we will have it done 1. Thorough review of referral to ensure safety and minimize risk factors. All referrals will have a scheduled "meet and greet" via Zoom or telephone interview. This interview will be conducted with the House Manager/Program Manager (to include the Director and/or Clinical Director if necessary). During the interview, staff will assess for level of care, see if the referral is appropriate for the current milieu in the home and complete the client specific competency review. If team deems referral is appropriate Staff will obtain verbal and written agreement of house rules and policies associated with our service delivery. Staff will complete the client specific competency and house manager will train staff on appropriate interventions. If the referral is a step down from a higher level of care (i.e. PRTF or Level III) or awaiting placement at a higher level of care (Level III or PRTF) staff will complete a Safety Plan. The Safety plan will be sent to the Clinical Director for review and approval. IMPLEMENTATION January 12, 2021 If the Referral is not appropriate: House Manager will seek consultation/review with team (i.e. Supervisor/Director/Clinical Director/COO) if needed. House Manager communicates reason for denial with referring source. This process will begin immediately as we are receiving referrals for all levels of care. Need to review opening packet and documentation (address high behaviors--property destruction, fire-setting, running away, aggression, etc). Review Client Specific Competency form to make adjustments (i.e. when was the last time client exhibited the behavior?). Review current Safety Plan that CARE Haven is using (do we need to add Clinical Director's Signature?). Determine the process for	V 115		

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V 115	Continued From page 28 documentation when referral is denied Goal for Improvement: Staff Training Section 3 - Strategies Specify a detailed plan to improve performance, as follows: Strategic objective - What we will do. Implementation measure - How we will know we've done it. Implementation timeline - When we will have it done. 2. Increase staff training in the following areas: crisis response, de-escalation techniques, and handling client disclosures. Currently Residential Coaches (RC) are trained in CPI (De-escalation Techniques); Have staffed trained in crisis response training CRISIS RESPONSE TRAINING BY CLINICAL DIRECTOR. Calming Children in Crisis, and Crisis Management Basis (Implemented January 15, 2021). Boundary Training in Relias for all new staff (IMPLEMENTED ON More detailed training in development of a safety plan and when to complete a safety plan DONE: NOVEMBER 19, 2020. More training on group and individual therapeutic/behavioral interventions Sexual abuse prevention (i.e. Darkness to Light training) Warning signs (mental health/risky behaviors) Diagnostic Specific training . Review the current training plan for Residential Coaches and tweak as necessary Determine what Safety Plan training is currently--Develop case example and have each staff member complete a safety plan Identify appropriate group and individual therapeutic/behavioral interventions (i.e. CRM training, Pressley Ridge (TRAINING will begin by January 22, 2021--5 week training), other trauma-informed training, etc.)	V 115		

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V 115	Continued From page 29 Review the Warning signs training Goal for Improvement: Supervision Section 3 - Strategies Specify a detailed plan to improve performance, as follows: Strategic objective - What we will do. Implementation measure - How we will know we've done it. Implementation timeline - When we will have it done 3. During transition times ("room-up," "lights out") staff will remain in direct eye-sight until the client is in their room 4. During sleep hours staff will complete random interval 30 minute checks 5. During times when a child goes away from the group (i.e. taking out the trash, walking to their room, etc.) staff will visually monitor the child as they complete the task and return to the area. 6. Administrative Watch to ensure compliance and supervision. 7. Implement a Program Manager position that will increase supervision of House Manager and Residential Coaches. Staff will physically monitor each kid as they go into their appropriate space Staff document intervals with actual time on "room checks" form During sleep hours (in between visual checks) staff will monitor security cameras and listen for alarms Schedule rotation for Admin Watch Create and Hire a Program Manager Position that will supervise the Care Haven House Manager to increase oversight and compliance Implemented September 11, 2020 Additional security cameras were put in place on Follow up to ensure process is being followed Determine implementation date for supervision when child leaves group area	V 115		

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V 115	Continued From page 30 Develop guidelines for Admin Watch and schedule for leadership Job description created and sent to HR. HR needs to approve job description and send formal offer to [Staff name]. [Staff name], President Chief Operations Officer." Review on 1/6/21 of a revised Plan of Protection dated 1/5/21 written by the President Chief Executive Officer revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? See attached: Strategic Planning Document titled QIP CARE HAVEN shared 1/05/21 at 8:20 P.M. Updated document titled QIP CARE HAVEN submitted 01/06/2021 at 2:30 P.M. See attachments: Timeline - emailed on 1/06/2021. Describe your plans to make sure the above happens. See attached Strategic Planning Document titled QIP CARE HAVEN See Document Draft titled: Administrative Watch Care Haven emailed on 1/06/2021. Review on 1/6/21 of page 2 of the revised Plan of Protection dated 12/21/20 written by the President Chief Executive Officer and the Chief Operations Officer revealed: "A Caring Alternative Quality Improvement Project Description Form Section 1 - Background Information Project Name: CARE Haven Content Area(s): X Dept./Service specific: CARE Haven Agency wide other Type of Project: X quality of service error	V 115		

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V 115	Continued From page 31 reduction Customer Service other Project Description: Responding to high acuity client needs/behaviors Project Manager: [Staff names] Project Team Members: [Staff names] Implementation Start Date: December 21, 2020 Timetable for Implementation: Evaluation Completion Date: Section 2 - Project Basis: CARE Haven currently has an open investigation with DHHS *DHSR regarding staff training and supervision. Leadership is conducting a thorough review of staff training and supervision related to children being placed in our respite facility. Goal for Improvement: Intake/Admission Process Section 3 - Strategies Specify a detailed plan to improve performance, as follows: Strategic objective - What we will do Implementation measure - How we will know we've done it Implementation timeline - When we will have it done 1. Thorough review of referral to ensure safety and minimize risk factors. All referrals will have a scheduled "meet and greet" via Zoom or telephone interview. This interview will be conducted with the House Manager/Program Manager (to include the Director and/or Clinical Director if necessary). Implementation date: Immediate. During the interview, staff will assess for level of care, see if the referral is appropriate for the current milieu in the home and complete the client specific competency review. Implementation date: Immediate. If team deems referral is appropriate Care Haven admission process will require a written	V 115		

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V 115	Continued From page 32 agreement of house rules and policies associated with out service delivery and client record. House Rules will require signature and approval from both client and guardian. Implementation Date: January 18, 2021. Frequency of targeted behaviors will be noted and intake packet will be updated. Staff will complete the client specific competency and house manager will train staff on appropriate interventions Implementation Date: January 18, 2021. Safety Plan Requirement if applicable. If the referral is a step down from a higher level of care (i.e. PRTF or Level III) or awaiting placement at a higher level of care (Level III or PRTF) or identified need due to at risk behaviors; staff will complete a Safety Plan. The Safety plan will be sent to the Clinical Director for review and approval. IMPLEMENTATION January 12, 2021. If the Referral is not appropriate: House Manager will seek consultation/review with team (i.e. Supervisor/Director/Clinical Director/COO) if needed. Process to document the review and disposition following the consultation. House Manager communicates reason for denial with referring source. January 25, 2021. This process will begin immediately as we are receiving referrals for all levels of care. Need to review opening packet and documentation (address high behaviors--property destruction, fire-setting, running away, aggression, etc) triggering the need for a Safety Plan. Review Client Specific Competency form to make adjustments (i.e. when was the last time client exhibited the behavior?). Review current Safety Plan that CARE Haven is using and add Clinical Director's Signature. Determine the process for documentation when referral is denied. Implementation Date: 01/18/2020... Goal for Improvement: Staff Training	V 115		

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V 115	Continued From page 33 Section 3 - Strategies Specify a detailed plan to improve performance, as follows: Strategic objective - What we will do Implementation measure - How we will know we've done it. Implementation timeline - When we will have it done. Section 3 - Strategies Specify a detailed plan to improve performance, as follows: Strategic objective - What we will do. Implementation measure - How we will know we've done it. Implementation timeline - When we will have it done 3. During transition times ("room-up," "lights out") staff will remain in direct eye-sight until the client is in their room 4. During sleep hours staff will complete random interval 30 minute checks 5. During times when a child goes away from the group (i.e. taking out the trash, walking to their room, etc.) staff will visually monitor the child as they complete the task and return to the area. 6. Administrative Watch to ensure compliance and supervision. 7. Implement a Program Manager position that will increase supervision of House Manager and Residential Coaches. Staff will physically monitor each kid as they go into their appropriate space Implementation Date: Immediate Staff document intervals with actual time on "room checks" form DONE: September 11, 2020. During sleep hours (in between visual checks) staff will monitor security cameras and listen for alarms Implementation Date: Immediate Schedule rotation for Admin Watch Implementation Date: January 11, 2021. Create and Hire a Program Manager Position that will supervise the Care Haven House Manager to	V 115		

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V 115	Continued From page 34	V 115		

increase oversight and compliance. Job description created and sent to HR. HR needs to approve job description and send formal offer to [Staff name] Implementation Date: January 25, 2021.
Implemented September 11, 2020 Additional security cameras were put in place (See Timeline Document emailed January 06, 2021. Determine implementation date for supervision when child leaves group area. Staff will have visual sight of client who leaves group until they return to group or are safely in room. Implementation Date: Immediate with documentation of implementation on January 12, 2021.
[Staff name], Chief Operations Officer and [Staff name] Chief Executive Officer."

Review on 1/6/21 of page 3 of the revised Plan of Protection dated 1/6/21 provided by the President Chief Executive Officer revealed:
"DRAFT Care Haven Administrative Watch

Administrator on Call: [Staff names]

Week of On Call Rotation: 01/11/2021 - 01/16/2021

Monday
Time Observed: _____ ____ Camera Observation ____ In Person Observation

Brief description of what was observed:

Competencies observed:
__ Visual supervision of clients __ Staff interacting with clients __ De-escalation of clients __ Following safety plan established __ Clients were safe __Tablet being monitored __ Test of systems (phones, cameras, social media firewall, sensors)

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V 115	Continued From page 35 __ Check-in with Residential Coaches Issues/Concerns that were observed: Tuesday Time Observed: _____ ____ Camera Observation ____ In Person Observation Brief description of what was observed: Competencies observed: __ Visual supervision of clients __ Staff interacting with clients __ De-escalation of clients __ Following safety plan established __ Clients were safe __Tablet being monitored __ Test of systems (phones, cameras, social media firewall, sensors) __ Check-in with Residential Coaches Issues/Concerns that were observed: Wednesday Time Observed: _____ ____ Camera Observation ____ In Person Observation Brief description of what was observed: Competencies observed: __ Visual supervision of clients __ Staff interacting with clients __ De-escalation of clients __ Following safety plan established __ Clients were safe __Tablet being monitored __ Test of systems (phones, cameras, social media firewall, sensors) __ Check-in with Residential Coaches Issues/Concerns that were observed: Thursday Time Observed: _____ ____ Camera	V 115		

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V 115	Continued From page 36 Observation ____ In Person Observation Brief description of what was observed: Competencies observed: __ Visual supervision of clients __ Staff interacting with clients __ De-escalation of clients __ Following safety plan established __ Clients were safe __Tablet being monitored __ Test of systems (phones, cameras, social media firewall, sensors) __ Check-in with Residential Coaches Issues/Concerns that were observed: Friday Time Observed: _____ ____ Camera Observation ____ In Person Observation Brief description of what was observed: Competencies observed: __ Visual supervision of clients __ Staff interacting with clients __ De-escalation of clients __ Following safety plan established __ Clients were safe __Tablet being monitored __ Test of systems (phones, cameras, social media firewall, sensors) __ Check-in with Residential Coaches Issues/Concerns that were observed: Saturday Time Observed: _____ ____ Camera Observation ____ In Person Observation Brief description of what was observed: Competencies observed: __ Visual supervision of clients __ Staff	V 115		

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V 115	Continued From page 37 interacting with clients __ De-escalation of clients __ Following safety plan established __ Clients were safe __Tablet being monitored __ Test of systems (phones, cameras, social media firewall, sensors) __ Check-in with Residential Coaches Issues/Concerns that were observed: Sunday Time Observed: _____ ____ Camera Observation ____ In Person Observation Brief description of what was observed: Competencies observed: __ Visual supervision of clients __ Staff interacting with clients __ De-escalation of clients __ Following safety plan established __ Clients were safe __Tablet being monitored __ Test of systems (phones, cameras, social media firewall, sensors) __ Check-in with Residential Coaches Issues/Concerns that were observed: On-Call Rotation Schedule: 01/11/2021 - 01/17/2021 - [Staff name] 01/18/2021 - 01/24/2021 - [Staff name] 01/25/2021 - 01/31/2021 - [Staff name] 02/01/2021 - 02/07/2021 - [Staff name] 02/08/2021 - 02/14/2021 - [Staff name] 02/15/2021 - 02/21/2021 - [Staff name] 02/22/2021 - 02/28/2021 - [Staff name] 03/01/2021 - 03/07/2021 - [Staff name] 03/08/2021 - 03/14/2021 - [Staff name] 03/15/2021 - 03/21/2021 - [Staff name] 03/22/2021 - 03/28/2021 - [Staff name] 03/29/2021 - 04/04/2021 - [Staff name] 04/05/2021 - 04/11/2021 - [Staff name]	V 115		

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V 115	Continued From page 38 04/12/2021 - 04/18/2021 - [Staff name] 04/19/2021 - 04/25/2021 - [Staff name] 04/26/2021 - 05/02/2021 - [Staff name] *[Clinical Services Director] will create a 3 month on-call rotation. The next schedule will be sent out by April 10th, 2021. Please, review dates and let [Clinical Services Director] know of schedule conflicts/absences so adjustments to the schedule can be made. Care Haven Daily Schedule 6:00-6:15 - Staff transition 6:15-7:00 - Staff planning 7:00 - 7:45 - Good morning: wake up, hygiene, breakfast, med pass 7:50 - 2:30 - School (weekend: staff planned activities/outings) 11:00 - 12:00 - lunch 2:30 - 3:15 - Staff planned activity/Outside Activity 3:15 - 3:30 - snack 3:30 - 4:00 - Room up/Clean Room 4:00 - 5:00 - Free time/Dinner prep 5:00 - 5:45 - Dinner 5:45 - 6:15 - Staff transition/Room up 6:15- 7:15 - Staff planned activity 7:15 - 8:00 - Showers/Hygiene 8:00 - 8:30 - Snack/Med Pass/Time Capsule Group 8:30 - Good night: Room up 9:00 - Lights out." CARE Haven is a respite facility for adolescents whose diagnoses included Major Depressive Disorder, Post-Traumatic Stress Disorder, Impulse-Control and Conduct Disorder, Attention-Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Adjustment Disorder, Generalized Anxiety Disorder, and Unspecified Trauma and Stressor Related	V 115		

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V 115	Continued From page 39 Disorder. Histories included being neglected, physically and sexually abused, irritability, refusal to comply, trouble eating/sleeping, impulsive behavior, outbursts of anger, running away and sexualized behaviors. According to facility documents, the supervision expectation for all clients was for staff to keep eyes on them at all times. Clients were to be observed while on computers doing school work, and accessing social media was prohibited. Staff meetings were held in July through November 2020 addressing facility protocols and expectations of keeping eyes on clients at all times, maintaining personal boundaries, not allowing access to social media, and sitting upstairs in a common area supervising clients while they were in their bedrooms. Once additional cameras were added to better view the upstairs hallway and bathroom door, staff were given a tablet in order to view the upstairs while completing other tasks downstairs during "room-ups." Despite staff meetings outlining expectations and individual staff write-ups on these issues, clients were still able to find opportunities, on more than one occasion, to avoid supervision and violate the rules of the facility. A client was able to access social media on at least 4 occasions and post sexualized pictures of herself as well as chat with males. Another female and male client were able to open and close their bedroom doors setting off the door alarms and meet in the bathroom on multiple occasions without staff checking on them. They reported "making-out" on these occassions with varying accounts of how far this went sexually. Another client was able to access social media and contacted her ex-boyfriend, who was under a restraining order, gave him the address to pick her up and set up a time and date to be at the facility. The client had a history of running away with this ex-boyfriend prior to	V 115		

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CARE HAVEN	2533 AIRPORT ROAD MARION, NC 28752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 115	Continued From page 40 coming to the facility. The two staff on duty, one being the Supervisor, were in full view of the client getting up and walking toward the front door after she stated her intention was to go upstairs. Instead of watching the client walk in the living room to ensure she accessed the stairway to go upstairs, the client walked out the front door. Staff were unaware the client left the facility until another client told staff she left the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1,000 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 115		