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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 7/15/21. The complaint was substantiated (Intake #NC00178864). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to develop and implement strategies and interventions to address 1 of 2 former client's (FC #1's) behaviors of running from the facility, aggression and illegal substance use. The findings are:

Review on 7/14/21 of FC #1's record revealed the following information;
-- A 15 year old female.
-- Admission date: December 18, 2020.
-- Discharge date: July 9, 2021.
-- Last date at the facility July 2, 2021.
-- Ran away from staff on July 2, 2021.
-- As of exit date of survey (7/15/21) FC #1 has not been located.
-- Diagnoses include Attention Deficit Hyperactivity Disorder-Combined Type with Severe Impulsivity, Disruptive Behavior Disorders-Oppositional Defiant Disorder & Conduct Disorder, Depressive Disorder, Cyclothymic Disorder, Anxiety Disorder, Post Traumatic Stress Disorder with Sleep Issues/Panic, Substance Use Disorder, Tobacco use, Unspecified Psychosis not due to a substance or known physiological condition, Rule Out Bipolar Disorder and Asthma.

Review on 7/14/21 of FC #2's record revealed the following information:
-- A 14 year old female.
-- Admission date: February 10, 2021.
-- Discharge date: July 9, 2021.
-- Discharged back to her Mother's home after

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reaching maximum benefits of the treatment at Youth Unlimited.
-- Diagnoses of Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder.

1. Review on 7/14/21 of FC #1's record revealed a CCA (Comprehensive Clinical Assessment) dated 11/11/20 documenting the following information:
-- Multiple instances of running from her home, sometimes for several days.
-- Lying about her age to be around older men.
-- Engaging in unsafe sex.
-- Smoking Marijuana frequently.
-- Physically fighting/assaulting peers.
-- Exhibiting poor decision-making skills and impulsive behaviors.

Review on 7/14/21 of FC #1's record revealed a Treatment Plan dated 12/7/20 with a target date of 6/24/21 documenting the following goals;
-- #1: Self-worth development
-- #2: Improve anger management skills
-- #3: Go to school and follow expectations and demonstrate compliance
-- #4: "Improve relationship development and skill & anger development"
-- #5: "Need for visits (to home) once deemed appropriate and safe"
-- #6: "Needed for Level III expectations"

Review on 7/15/21 of FC #1's Treatment Plan dated 12/7/20 with a target date on 6/24/21 documenting the following strategies and interventions for staff to use with this client to achieve the above goals;
-- "CBT - Cognitive Behavioral Therapy"
-- "MI - Motivational Interviewing"
-- "OARS - Open Ended Questions to engage client, Affirmation to affirm client's story,

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V 112	Continued From page 3 Reflection to further dialogue and Summation to insure understanding of client's point of view occurs" -- "Trauma Informed Care" -- "ART - Aggressive Replacement Training" -- No documentation of or identification of interventions/strategies to address running away, aggression or illegal substance use behaviors. -- No stratagies/interventions to address AWOL (absent without leave), aggression or illegal substance use behaviors. Review on 7/14/21 of FC #1's record revealed documentation on the above Treatment Plan review by staff on 5/26/21 indicating "progress towards goal:" -- " ...Client went AWOL from school on two occasions (since the last review on 4/1/21) in May resulting in a 10 day (out of school) suspension." -- "Client attempted to hit another peer (FC #2) who was antagonizing her and staff intervened and she was able to process through event." -- "[FC #1] is easily frustrated with challenging peers and on one occasion this review period in late May attempted to hit this client (FC #2) ..." -- "Client has been home this review period and Mother has halted visits and MCO (Managed Care Organization) Care Coordinator was aware at CFT (Child and Family Team - a review of the current Treatment Plan), due to Client going AWOL 2X (while at) home, being accused of smoking THC (Tetrahydrocannabinol-the main psychoactive compound in cannabis/Marijuana that produces the 'high' sensation) and stealing something from her Sister ... Mother wants client placed in TFC (a Therapeutic Foster Care home) and not return home at this time ..."" Review on 7/14/21 of FC #1's record revealed a subsequent Treatment Plan dated 6/2/21 with a	V 112		

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target date of 6/1/22 documenting the following information;
-- The goals remain the same as the previous plan.
-- Identification under Goal #2 (Improve anger management skills) of client utilized skills "such as deep breaths, talk-it-out, walk about, exercise, journal, writing, self-time outs/take 5, crafts, etc. to regulate emotions and make informed, positive decisions thereby eliminating risk taking such as going AWOL, and/or illegal behaviors."
-- Identification under Goal #4 (Improve relationship development and skill & anger development) for client to "demonstrate ability to regulate herself with peers and adults by practicing breathing, journaling, talk-it-out and walk-away skill sets when frustrated to improve emotional response and work towards resolving conflict in a positive way 90% of the time."
-- The staff "Support/Interventions" remain the same as the previous Treatment Plan.
-- No stratagies/interventions for staff to address AWOL, aggression or illegal substance use behaviors.

2. Review on 7/14/21 of the IRIS system (Incident Response Improvement System) revealed two incident reports were entered for both FC #1 and FC #2 for an event that took place on 6/24/21 as follows;
-- FC #1: "Client (FC #1) was upset at peer (FC #2) for taking her property. Other consumer (FC #2) started saying things about her family and calling her vulgar names. [FC #1] was unable to compose herself and attacked client (FC #2) despite staff attempts to stop. Client (FC #1) fractured her wrist hitting peer's head (FC #2). She hurt her thumb and slightly twisted her ankle as well. Client stopped when police arrived shortly after it began. Client calmed down and

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went to the ER (emergency room) without issue. Client completed shift in stable mood... Client has dealt with this peer (FC #2) on many occasions and avoided physically attacking but was unable to this time. We will continue to help her with regulation skills and separation from peer."
-- FC #2: "Client (FC #2) was upset with another peer (FC #1) for telling staff on her and not wanting to give back an item that belonged to peer. Client (FC #2) started tearing up the house, throwing things, hitting walls, verbally assaulting peer (FC #1), and refusing to calm down. Other consumer (FC #1) got to peer after getting by staff. [FC #2] was punched in her head a few times. Staff took to ER for exam. Client returned after hospital visit and continued to become unruly. Staff had to call 911 for their safety. Client calmed down when Sheriff arrived and went to bed."

Review on 7/14/21 of Discharge Summaries from both FC #1's and FC #2's emergency room treatment on 6/24/21 revealed the following information:
-- FC #1 was taken to the ER on 6/24/21 and treated for "Gamekeeper's Thumb of Right Hand (an injury to the thumb on the little finger side at the second joint from the thumbnail), Mild Ankle Sprain and Occult Fracture of Scaphoid Bone of Right Wrist (broken wrist). Use Ibuprofen 600 mg. (miligrams) as needed." She was treated with a splint and a referral was made to an Orthopedist for follow-up for the injury.
-- FC #2 was taken to the ER also on 6/24/21 and treated for a "Concussion (a traumatic brain injury that affects your brain function)."

Interview on 7/15/21 with the Clinical Director revealed the following information;
-- FC #1 never ran from the facility itself.

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V 112	Continued From page 6 -- FC #1 and FC #2 did not get along together very well. -- FC #1 and FC #2 had made some progress in treatment. -- It is the facility's policy if a client is gone over 7 days (FC #1) they are considered discharged. This deficiency is cross referenced into 10A NCAC 27G .1704, MINIMUM STAFFING REQUIREMENTS, Tag V-296 for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present	V 296		

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V 296	Continued From page 7 and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure it maintained the minimum number of staff required while providing direct care services affecting 1 of 1 current client (Client #3) and 1 of 2 former clients (FC #2). The findings are: Cross-Reference: 10A NCAC 27G .0205, ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN, Tag V-112. Based on interview and record review, the facility failed to develop and implement strategies and interventions to address 1 of 2 former client's (FC #1's) behaviors of running from the facility,	V 296		

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V 296	Continued From page 8 aggression and illegal substance use. Review on 7/14/21 of FC #1's record revealed the following information; -- A 15 year old female. -- Admission date: December 18, 2020. -- Discharge date: July 9, 2021. -- Last date at the facility July 2, 2021. -- Ran away from staff on July 2, 2021. -- As of exit date of survey (7/15/21) FC #1 has not been located. -- Diagnoses include Attention Deficit Hyperactivity Disorder-Combined Type with Severe Impulsivity, Disruptive Behavior Disorders-Oppositional Defiant Disorder & Conduct Disorder, Depressive Disorder, Cyclothymic Disorder, Anxiety Disorder, Post Traumatic Stress Disorder with Sleep Issues/Panic, Substance Use Disorder, Tobacco use, Unspecified Psychosis not due to a substance or known physiological condition, Rule Out Bipolar Disorder and Asthma. -- No assessment or documentation that this client could be transported with less than the minimum amount of staff as required by rule. Review on 7/14/21 of FC #2's record revealed the following information: -- A 14 year old female. -- Admission date: February 10, 2021. -- Discharge date: July 9, 2021. -- Discharged back to her Mother's home after reaching maximum benefits of the treatment at Youth Unlimited. -- Diagnoses of ODD (Oppositional Defiant Disorder) and ADHD (Attention Deficit Hyperactivity Disorder). -- No assessment or documentation that this client could be transported with less than the minimum amount of staff as required by rule.	V 296		

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V 296	Continued From page 9 Review on 7/12/21 of Client #3's record revealed the following information: -- A 14 year old female. -- Admission date: 1/20/21. -- Diagnoses include ADHD - Combined Type, Odd and Unspecified Trauma and Stressor Disorder. -- No assessment or documentation that this client could be transported with less than the minimum amount of staff as required by rule. Interview on 7/15/21 with Staff #1 revealed: -- She worked on 7/2/21 with Staff #2 on second shift (3:00 pm until 11:00 pm). -- She transported FC #2 on 7/2/21 to her home for her home visit and FC #1 rode along. -- FC #1 was left in the van unsupervised no more than 30 seconds for her to walk FC #2 to her front door. -- FC #1 ran from the facility van while unsupervised. -- She called the police and Staff #2 to make them aware of the incident. -- She rode around the neighborhood and searched for FC #1. -- She was informed by a neighbor that FC #1 had run from behind the back yard of the house. -- FC #1 shared on her social media page pictures of herself in what appeared to be a hotel room. -- The Detective on the case called last week and information was shared from the social media postings. Interview on 7/15/21 with Staff #2 revealed: -- She worked on 7/2/21 with Staff #1 on second shift (3:00 pm until 11:00 pm). -- Normally staff take only the client having a home visit to their home, but on this day	V 296		

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management was asked if it was OK for FC #1 to ride along while transporting FC #2 home, and staff was given consent to do so.
-- She remained at the group home with the current client.
-- Staff #1 telephoned her to make her aware of FC #1 jumping out of the van.
-- Staff #1 told her that FC #1 left a note in the van written on a torn piece of paper in the van that said, "I can't do another six months."
-- She received a call from Staff #1 about the incident and requested she call management as her cell phone was dying.
-- Staff #1 told her that she rode around searching for FC #1 prior to returning to the group home.
-- Staff #1 told her that a neighbor of FC #2 shared that she saw FC #1 hiding in the back yard and came out when a car came to pick her up and the client was carrying a blue bag.
-- She spoke with FC #2 and asked if she was aware of FC #1 running away, and she stated she had mentioned it in the past, but she didn't know when she would actually do it.
-- FC#2 shared that FC #1 may have been connecting with a guy that was 47 years old.
-- FC #1 shared on her social media page of her in a hotel room.
-- FC #1 posted photo of herself with a new tattoo.
-- This social media information was shared with the Detective on the case.

Interview on 7/14/21 with the Qualified professional revealed that he could not recall giving permission for only 1 staff to transport clients.

Interview on 7/15/21 with the Clinical Director revealed the following information:

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V 296	Continued From page 11 -- Staff was trying to minimize and separate clients to lessen their behaviors. -- He did not believe anyone gave staff permission for only one staff to transport clients. -- FC #1 never ran from the facility itself. -- FC #1 and FC #2 did not get along together very well. -- FC #1 and FC #2 had made some progress in treatment. -- It is the facility's policy if a client is gone over 7 days (FC #1) they are considered discharged. Review on 7/15/21 of the Plan of Protection written by the Clinical Director on 7/15/21 revealed the following information; "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm: Insure staff ratio is in compliance to insure supervision at all times. The goal is to meet the needs of clients. Describe your plans to make sure the above happens: Plan is occurring now." FC #1 and FC #2 were being treated by the facility for behaviors associated with diagnoses such as Attention Deficit Hyperactivity Disorder-Combined Type with Severe Impulsivity, Disruptive Behavior Disorders-Oppositional Defiant Disorder & Conduct Disorder, Depressive Disorder, Cyclothymic Disorder, Anxiety Disorder, Post Traumatic Stress Disorder with Sleep Issues/Panic, Substance Use Disorder and Tobacco Use. FC #2 was being transported home for a home visit by a single staff on 7/2/21 instead of the required number of staff. FC #1 also rode along for this trip. Upon arriving at FC #2's home, FC #1 ran from staff. As of exit date of survey (7/15/21), FC #1 has still not been located. In May 2021, FC #1's Mother would no longer	V 296		

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allow her to come home for any visits. This was due to FC #1's unacceptable behaviors such as running away from the home, stealing, lying, substance use and engaging in unsafe sex practices.
None of the clients (FC #1, FC #2 or Client #3) had any documentation in their charts indicating that they were approved to be transported by facility staff in a number lower than the minimum number of staff required by rule.

FC #1 exhibited AWOL behavior while at school 2 times resulting in a 10 day out of school suspension.
FC #1 displayed 2 instances of aggression against FC #2 some time between 4/1/21 and 5/26/21 and again on 6/24/21. The later aggression resulted in injuries to both clients requiring a trip to the emergency room for testing and medical evaluation. FC #1 sustained a broken wrist and a sprain of her ankle, and FC #2 sustained a concussion.

This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.