Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-200	A. BUILDING: ______ B. WING ______	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CYCLES RESIDENTIAL FACILITY LEVEL III	2541 US HIGHWAY 70 MEBANE, NC 27302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on September 3, 2021. Deficiency cited. This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children or Adolescents	V 000	Solutions Community Support Agency, LLC / Life Cycles Residential Facility will develop and implement the use of a comprehensive review / assessment tool to be used prior to admission This tool will be used in an attempt to obtain all pertinent information in regards to all potential clients' behaviors and needs, to include but not limited to elopement issues or concerns. Also, an elopement prevention goal will be included in all residential clients' PCPs. The above will be implemented by 10/8/2021, in an attempt to prevent client elopements. The review/assessment tool will be used by ED., QPs and/or Clinicians). Clients will be monitored daily by staff. PCP's will be reviewed/updated at least monthly.	10/8/2021
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		

DHSR - Mental Health
SEP 15 2021
Lic. & Cert. Section

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Executive Director (X6) DATE 9/13/2021

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This Rule is not met as evidenced by:
Based on record review and interview the facility failed to develop and implement goals and strategies to address one of three audited clients (#1) behavior including elopement. The findings are:

Review on 8/24/21 of Client #1's record revealed:
-Age 15 years old.
- Admission date of 7/19/21.
- Diagnoses of Disruptive Impulsive Control, Conduct Disorder and Unspecified Trauma and Stressor Related Disorder
- Treatment plan dated 6/30/21.
-Treatment plan failed to provide interventions and strategies to address the elopement and leaving the home without permission.
-Elopement on 8/22/21.

Review on 8/25/21 of Level II Incident report dated 8/22/21 revealed:
-"At 5p.m. Staff made client aware that dinner was ready. Staff observed a necklace with a tag on [Client #1] that was not [Client #1's]. [Client #1] stated [Client #1] bought when [staff #4] and the [Qualified Professional] went out to store today. [Staff #4] stated [Client#1] did not purchase any type of necklace just shoes. [Staff #2] and [Staff #3] questioned [Client #1] about where [Client #1] got the necklace and admitted finally [Client #1] grabbed it off the rack and put in [Client #1's] pocket when [Doris #4] turned her head. [Staff #2] and [Staff #3] made client aware that it was not right to steal. [Staff #2] encouraged [Client #1] to follow the rules and regulations when they are on an outing or store. [Staff #2]

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explained to [Client #1] that [Client #1] will have consequences for [Client 3's] actions. [Client #1] stated, "Okay I understand." At 5:15 p.m. when [Staff #2] off the alarm so [Client #1's] housemates throw trash in the big trash can outside, [Client #1] immediately stormed out the back door begin to run down the street into the wooded area. [Staff #2] prompted/redirected [Client #1] to return but [Client #1] ignored [Staff #2's] request by running into the wooded area. First [Staff #2] called on the call [Program Director] to assist with the elopement of [Client #1]. The [Program Director] stated he would be at the facility withing 5-10 minutes because [Program Director] coming from the grocery store. [Staff #3] continued to monitor the other consumers while [Staff #2] assisted with the search of [Client #1]. [Program Director] drove around the surrounding neighborhood for approximately 30 minutes and was unsuccessful locating [Client #1]. Also, the [Program Director] contacted [Client #1's] guardian that [Client #1] eloped from the facility. After searching the area for about 30 minutes, [Program Director] called [Staff #2] to direct [Staff #2] to call 911 to inform them of [Client #1] eloping from the facility. Sheriff arrived to the facility about 5:48 p.m. to gather information on [Client #1] and picture of [Client #1] as well. Officer stated they will look for [Client #1] for about an hour around the surrounding area and after 1 hour the Officer will file a missing/amber alert of [Client #1] eloping from Solutions CSA. [Program Director] continued to drive around the area but was unsuccessful locating [Client #1]. [Program Director] directed [Staff #2] and [Staff #3] to make sure they check the windows were locked and set the house alarm on stay immediately."

Review on 8/25/21 of Client #1's

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Neuropsychological Assessment dated 6/1/21 revealed:
- "[Client #1] is a 15-year old black male who was admitted to [Psychiatric Hospital] on March 25, 2021 due to a series of behavioral difficulties, including increasing defiance, theft, property destruction and elopement ..."

Client #1 was not available for interview.

Interview on 8/25/21 with Staff #2 revealed:
-Worked weekend 7a.m. - 7p.m.
-Client #1 left the house about 5:20 - 5:30p.m.
-Client #1 was "acting good and normal" like nothing was bothering him.
-Client #1 got up and did his morning chores.
-Client #did not do anything unusual.
-Client #1 went shopping with other staff.
-Client #1 showed a necklace upon return from shopping about 2:30 - 3:00 p.m.
-Client #1 purchased tennis shoes and a belt.
-Client #1came in and said he needed scissors and showed the necklace.
-She looked on the receipt and didn't see where client #1 bought the necklace.
-Client #1 admitted that he took the necklace when staff was not looking. -
-She told client #1 he would get some consequences.
-Client #1 acted as if everything was fine.
-Client #1 just laughed when consequences were mentioned.
-Client #1's consequences was early bedtime.
-Client #1 had early bedtime before.
-Prior to the elopement client #1 was a pretty good kid.
-Clients did not like early bed.
-Clients go in their rooms at from 4 -5 p.m. for staff to prepare dinner.
-Client #1 took his 5p.m. medication for his

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stomach.
-They turned alarmed off to complete chores.
-Another client had the door opened to take the garbage out and client #1 ran out the door.
-Client #1 did not say anything.
-She tried to call client #1 back but he kept on running into the wooded area.
-Client #1 tried calling family days prior and never received an answer.
-Client #1's phone time was at 6p.m daily.
-Client #1 always talked about family not answering the phone.
-She called the Program Director and 911.
-The Program Director was in the area and came immediately.
-Client #1 never discussed wanting to run.
-Client #1 was interacting with the other clients before he ran.
-The consequence was starting that evening.
-Client #1 responded with yes ma'am and okay when consequences were discussed.
-The other clients was with the other staff.

Interview on 8/25/21 with Staff #3 revealed:
-She worked since 7a.m.
-The weekends was 12 hours shift from 7:00 a.m. - to 7p.m.
-Client #1 left this pass Sunday without permission.
-Client #1 had been shopping for school clothes with other staff.
-Client #1 returned from shopping about 3:45 p.m.
-She and staff #2 learned that client #1 stole a necklace.
-She and staff #2 asked for the receipt.
-The receipt only had the receipt with the belt information.
-Client #1 had consequences for stealing.
-Client#1 admitted to stealing the necklace.

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-The necklace was a fake gold necklace with a diamond cross.
-Client #1 had to go to bed early at 7:00 p.m.
-Normal time is 10:00 pm.
-She and staff #2 cooked for clients 4p.m.
-Clients had to go in their rooms at 4 and come back out at 5:00.
-About 5:15 they turned the alarm off.
-The clients had different chores.
-One of the client's chore was to take the trash to the end of the road.
-Clients had of list of things to do.
-They turned off the alarm and client #1 ran out the back door.
-This was regularly done.
-The alarm had to be turned off to take out trash and get the mop.
-The- mop was on the back porch.
-After completing chores, the alarm was be turned back on.
-When another client opened the door to take out the trash client #1 ran.
-Staff #2 went to the road to call for the client #1.
-Staff #2 was saw client #1 walking to the wooded area.
-Client #1 started running.
-Staff #2 called the Program Director and 911.
-It was a storm that day and 911 never picked up.
-Staff #2 then called the police department directly and they picked up.
-The other clients were in the house cleaning.
-Client #1 was acting, "normal."
-There was no verbal aggression.
-Client #1 did not talk to anyone on the phone.
-Confirmed this was client #1's first elopement.
-She denied client #1 ever being aggressive.
-During phone time parents never picked up.
-Before client #1 ran he was talking to clients and staff.
-They were talking about the sneakers client #1

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bought and how nice they were.

Attempted interview on 9/1/21 and 9/2/21 of the Referral Social Worker. Messages left and no call back upon exit.

Interview on 9/3/21 with the Program Director and Executive Director revealed:
-Confirmed the client #1 left the facility without permission.
-The agency did not find out about client #1's elopement history until the incident occurred.
-They would continue to maintain the alarms in the home.
-Focus more on elopement issues during the interview admission process.
-During pre-admission they would have recommended a higher level of care.
-Staff would continue to process with clients during stressful situations.
-The agency would continue no hands contact with clients.
-Staff made the right decision by calling client #1 back to process with him.
-Staff followed the protocol by contacting the Program Director, police and guardian.
-Treatment Plans would continue to be reviewed and updated monthly.
-Client #1 was found and located with a family member.
-The agency was working with the guardian to locate new placement.