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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 1/26/22. The complaint was unsubstantiated (intake #NC00184145). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. The survey sample consisted of audits of 4 current clients and 2 former clients.	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	V 109		

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V 109	Continued From page 1 MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews, and interviews, 3 of 5 qualified professionals (QP #2, QP #5 and the Licensee) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Cross Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296) Based on record review and interviews, the facility failed to ensure 1 of 2 former client's (FC #5) individualized needs were provided as specified in the treatment plan. Review on 1/19/22 of the Qualified Professional (QP) #2's record revealed: - Hire Date: 11/27/18 - Position: Qualified Professional - She had a master's degree. - The QP #2 has a degree and work history that qualifies her as a Qualified Professional. Review on 1/19/22 of the QP #5's record revealed:	V 109		

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V 109	Continued From page 2 - Hire Date: 3/9/11 - Position: Qualified Professional - She had a master's degree in counseling. - The QP #5 has a degree and work history that qualifies her as a Qualified Professional. Review on 1/19/22 of the Licensee's record revealed: - Hire Date: 1/1/01 - Position: Qualified Professional - The Licensee has a degree and work history that qualifies her as a Qualified Professional. Interview on 1/18/22 with QP #5 revealed: - She and QP #2 would be responsible for ensuring 2 staff and former client (FC) #5's one on one worked each day. Interview on 1/14/22 with the Licensee revealed: - She referred to her QP staff who had a master's degree as a "Master Level QP." - She did not feel FC #5 really needed a one-on-one staff on 3rd shift. Review on 1/21/22 and 1/26/22 of the Plan of Protection dated 1/21/22 written by the Licensee revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Miracle Houses Inc. will review the training of Person-Centered Plan Training and Person-Centered Thinking and the roles and responsibilities of a Qualified Professional and Associate Professional to ensure competencies in providing quality care treatment to consumers. Still will continue to schedule two to three staff on every shift to meet ratio and consumers treatment need. This plan of action will take place immediately, Friday January 21, 2022. [QP #7] will implement this process."	V 109		

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V 109	Continued From page 3 This deficiency constitutes a re-cited deficiency. This facility is a 24-hour residential treatment, staff secure facility which serves clients requiring continuous supervision, behavioral intervention and a high level of support to meet their needs. Former client #5 was a 13-year-old male with diagnoses of Attention Deficit Hyperactivity Disorder and Conduct Disorder. The former client had a history of: lying, stealing, setting fires, and once he became a client in the group home he started having AWOL (absent without leave) behaviors. On 12/20/21 FC #5 eloped with client #1. FC #5 was found over 4 hours later by the police in a stolen car. FC #5's treatment plan indicated he would have a Master Level QP staff as his one on one due to his AWOL behaviors. One of the two identified staff who was supposed to be FC #5's one on one did not know he was FC #5's one on one. The Licensee indicated FC #5 did not need a one on one staff during 3rd shift. The former client reported he did not have a one on one staff while living in the group home. This deficiency constitutes a Failure to Correct the Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days	V 112		

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V 112	Continued From page 4 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. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to develop and implement strategies affecting 1 of 4 current clients (#1) and 2 of 2 former clients (FC #5 and FC #6). The findings are: Review on 1/11/22 of FC #5's record revealed: - Admission date: 8/16/21 - Discharge date: 12/22/21 - Age: 13 - Diagnoses: ADHD (Attention Deficit Hyperactivity Disorder), Combined type and Conduct Disorder	V 112		

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V 112	Continued From page 5 - Review of FC #5's Comprehensive Clinical Assessment dated 3/3/21 revealed: "The guardian [FC #5's mother] reports [FC #5] has to be supervised at all times due to frequently playing with matches/lighters, stealing from others in the home and neighbors, smoking cigarettes when found and lying." - Review of FC #5's PCP (Person Centered-Profile): "Update/Revision Plan Signatures" dated 11/23/21 revealed: "Person Responsible for the PCP: The following signature confirms the responsibility of the QP (Qualified Professional)/LP (Licensed Professional) for the development of this PCP. The signature indicates agreement with the services/supports to be provided. Signature: [the Licensee]" - Review of FC #5's discharge plan: "Reason for Discharge: ...[FC #5] displayed AWOL (Absent Without Leave) weekly." - There were no strategies developed or implemented to address FC #5's safety or AWOL behaviors. Review on 1/20/22 of Child and Family Team (CFT) meeting notes and updates for FC #5 revealed: -8/6/21 Treatment plan developed - no AWOL behaviors mentioned -9/9/21 Update - FC #5 "engages in AWOL behaviors" with no specific strategies to address these behaviors -10-4-21 Update - FC #5 "continues to engage in AWOL behaviors" with no specific strategies to address these behaviors -11/23/21 Update - FC #5 "continues to engage in AWOL behaviors" with no specific strategies to address these behaviors -12/14/21 Update - FC #5 "continues to AWOL from the facility, stealing cars and joy riding around the city" with no specific strategies to	V 112		

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V 112	Continued From page 6 address these behaviors Review on 1/20/22 of FC #6's record revealed: - Admission date: 9/13/21 - Discharge date:11/11/21 - Age: 17 - Diagnoses: Oppositional Defiant Disorder (ODD); ADHD; MDD (Major Depressive Disorder); Unspecified Anxiety and Cannabis Use Disorder - Review of FC #6's PCP dated 9/17/21 revealed: "Will not exhibit any incidents of inappropriate behaviors as evidenced by remaining in his assigned area throughout the night per shift note documentation and staff report after bedtime. [FC #6] will refrain form displaying AWOL behaviors." - Further review of FC #6's PCP revealed: "Engage client in activities in which he can practice displaying positive behavior and making good choices and refrain from AWOL behaviors." - Review of FC #6's PCP "Update/Revision Plan Signatures" dated 9/17/21 revealed: "Person Responsible for the PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided. Signature: [the Licensee]" - Review of FC #6's discharge plan: "Reason for Discharge: [FC #6] received a 30-Day Notice of Discharge on 9.20.2021 due to consistent AWOL behaviors taking peers with him and leaving the facility for hours at a time. Following an AWOL incident on 10.31.2021 [FC #6] was admitted to [hospital] on 11.1.2021 for observation ..." - There were no individualized strategies in place to ensure FC #6's safety and to address runaway behaviors. Review on 1/20/22 of CFT meeting notes and updates for FC #6 revealed:	V 112		

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- 9/17/21 Update- FC #6 was transitioned to Miracle Houses Valley Brook I due to "constant AWOL behaviors" in another facility owned by the Licensee. "[FC #6] was transitioned to Troutman (Miracle Houses Valley Brook I) where he has gone AWOL once. No specific goals or strategies to address these behaviors.
- 10/18/21 Update- A 30-day notice of discharge due to FC #6 "continued to display AWOL behaviors."

Review on 1/11/22 of client #1's record revealed:
- Admission date: 5/28/21
- Age: 16
- Diagnoses: Disruptive Mood Dysregulation Disorder (DMDD); Conduct Disorder, Childhood Onset; Intellectual Disability, mild and Cannabis Use Disorder, Severe
- Review of client #1's admission assessment dated 5/27/21 revealed: "Client also displayed property destruction, AWOL behavior and threats."
- There were no individualized strategies in place to ensure client #1's safety and to address runaway behaviors.

Review on 1/20/22 of CFT meeting notes and updates for client #1 revealed:
- 11/9/21 Update - "AWOL behaviors on multiple occasions with his peers" with no specific strategies to address these behaviors.
- 12/23/21 Update -"Miracle Houses was officially given there 30-day notice do to [client #1's] AWOL behaviors today" with no specific strategies to address these behaviors.
- 1/14/22 Update - "[Client #1] has struggled with being unable to communicate with his family and continues to participate in inappropriate behaviors such as AWOL behaviors, stealing from local stores and smoking tossed cigarettes ..." There

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were no specific strategies to address these behaviors.

Runaway Incident #1:

Review on 1/11/22 of the Incident Response Improvement System (IRIS) revealed:
- Date of Incident: 9/11/21
- Time of Incident: 1:30 am
- Consumer's name: FC #5
- Name of Person Completing this form: Therapist
- FC #5 had become upset and walked out the front door. Staff (unknown which staff) lost sight of FC #5 and contacted the police. The police located FC #5 and brought him back to the group home in handcuffs. It is unknown from the report when FC #5 was brought back to the group home.

Runaway Incident #2:

Review on 1/20/22 of the IRIS revealed:
- Date of Incident: 9/18/21
- Time of Incident: 1:00 am
- Consumer's name: FC #5
- Name of Person Completing this form: Therapist
- At 10:03 pm staff (unknown which staff) observed that FC #5 was not in his bedroom and his bedroom window was open. Staff checked around the facility and then contacted the police. The police returned FC #5 to the group home. It is unknown from the report when FC #5 was brought back to the group home.

Review on 1/20/22 of the IRIS revealed:
- Date of Incident: 9/18/21
- Time of Incident: 1:00 am
- Consumer's name: FC #6

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- Name of Person Completing this form: Therapist
- At 10:03 pm staff (unknown which staff) observed that FC #6 was not in his bedroom and his bedroom window was open. Staff checked around the facility and then contacted the police. The police returned FC #6 to the group home. It is unknown from the report when FC #6 was brought back to the group home.

Review on 1/20/22 of the Police Report revealed:
- Date/time reported: 9/18/21 at 22:03 (10:03 pm)
- Name: FC #6 and FC #5
- "On 9/18/21 at 2203 (10:03 pm) received a call of a runaway at 245 Valleybrook Ln. (Lane). Myself and [police officer] checked the area for approximately 25 minutes and did not locate either of the juveniles. I made contact at 245 Valleybrook Ln with [staff #10], she advised that she made a round at 2145 and both males was in their rooms. [Staff #10] then made a round at 2203 and both males was gone. [Staff #10] advised both males left the residence thru the window ...On 9/19/21 at 0030HRS (12:30 am) I was on route patrol ...when I located two males subjects walking ...two male subjects ended up being the juveniles that was missing form 245 Valleybrook. Myself and [police officer] transported both back to 245 Valleybrook Ln."

Runaway Incident #3

Review on 1/20/22 of the IRIS revealed:
- Date of Incident: 10/9/21
- Time of Incident: 12:05 am
- Consumer's name: FC #5 and FC #6
- Name of Person Completing this form: Therapist
- Staff did a 15-minute bed check and FC #5 and FC #6 were missing at 12:05 am. Staff contacted

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the police and on-call and guardians. On 10/9/21 at 3:45 pm FC #5 and FC #6returned to the group home via "a car dropping" FC #5 and FC #6 off at the group home. It is unknown from the report when FC #6 and FC #6 were brought back to the group home.

Review on 1/20/22 of the Police Report revealed:
- Date/time reported: 10/8/21 at 21:31 (9:31 pm)
- Name: FC #5 and FC #6
- "On October 8, 2021 at approximately 9:30 PM, I received a call in regards to two runaway about 15 min prior to calling for my assistance. And they had attempted to locate them, one of the male workers said that the employee of the [local gas station] ...
saw the two boys come in and steal a black and mild and a lighter then headed west behind the [local gas station]. I searched the whole area and was unable to locate.
First juvenile is [FC #5] and has been entered into NCIC (National Crime Information Center)
...Second juvenile is [FC #6] and has been entered into NCIC. [FC #6] is still entered as missing from [police department] ...On 10/09/2021 at approximately 1:30pm, [police officer], received a call for a missing person at the Miracle House, located at 245 Valleybrook Lane. While finishing my call, I was able to make contact with [FC #5] and [FC #6]. They had returned to Miracle House on their own and were in good health."

Runaway Incident #4:

Review on 1/11/22 of the IRIS revealed:
- Date of Incident: 10/9/21
- Time of Incident: 12:30 pm
- Consumer's name: Client #1

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V 112	Continued From page 11 - Name of Person Completing this form: Therapist - Client #1 "refused to listen to staff (unknown which staff) share tips for him to regain his composure instead of leaving the facility without permission." Client #1 ran into the bushes and staff lost line of sight. Staff contacted police. The police returned client #1 back to the group home. It is unknown from the report when client #1 was brought back to the group home. Runaway Incident #5 Review on 1/20/22 of the IRIS revealed: - Date of Incident: 10/9/21 - Time of Incident: 2:45 pm - Consumer's name: Client #1 - Name of Person Completing this form: QP #3 - Client #1 stated that he was upset for not being allowed to participate in the activities due displaying non-compliant behaviors and smoking. Client #1 stated that nobody listens to him about how he really feels regarding returning home to his family. Client #1 walked out of the facility without permission of staff. Staff searched the area and called the police. It is unknown from the report when client #1 was brought back to the group home. Runaway Incident #6 Review on 1/20/22 of the IRIS revealed: - Date of Incident: 10/9/21 - Time of Incident: 4:15 pm - Consumer's name: Client #1 - Name of Person Completing this form: Therapist - Client #1 expressed his agitation and inability to stay still and wanted to be away from the Level III facility because of feelings: isolation, depression	V 112		

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and loneliness. Staff urged client #1 to remain safe and to process with staff about his emotions instead of displaying AWOL behaviors. Client #1 left the group home from his bedroom window. Staff (unknown which staff) searched for client #1 in the area. The police were called. The police returned client #1 to the group home. It is unknown from the report when client #1 was brought back to the group home.

Runaway Incident #7

Review on 1/20/22 of the IRIS revealed:
- Date of Incident: 10/31/21
- Time of Incident: 7:15 pm
- Consumer's name: FC #5 Note: FC #6 and client #1 were also involved with this incident.
- Name of Person Completing this form: Therapist
- Staff (unknown which staff) prompted FC #5 to prepare to complete his nightly hygiene routine. Staff urged FC #6 to ensure he refrains from being rude and disrespectful towards his peers and staff. FC #6 stated he was frustrated and tired and wanted to go to bed. Staff conducted 15-minute checks and noticed FC #5 was missing and his window was open. Also noticed that client #1 and FC #6 were missing and their windows were open. Staff searched for all the clients in the neighborhood and located the clients, but they ran from the staff. The police were called. The police returned FC #5, FC #6 and client #1 to the group home. It is unknown from the report when the clients were brought back to the group home.

Review on 1/20/22 of the Police Report revealed:
-Date/time reported: 10/31/21 at 19:43 (7:43 pm)
- Name: Client #1, FC #6 and FC #5
- On 10/31/21 around 1945HRS (7:45 pm)

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	MHL049-155	A. BUILDING: _____ B. WING _____	R-C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRACLE HOUSES VALLEY BROOK I	245 VALLEY BROOK LANE TROUTMAN, NC 28166

(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 112	Continued From page 13 responded to runaway juveniles at 245 Valleybrook Ln. When I arrived spoke with caller. He advised that the three male subjects had left the house earlier around 1930HRS. He road around the area to look for them before calling. The caller located the runaways ...but when he went to turn around they fled on foot. Myself and [police officer] just the area for about 30 minutes and was unable to locate. All three juveniles will be entered missing into NCIC ...On 11/1/21 at 0530HRS (5:30 am) myself and [police officer] responded to a report of a 4-wheeler driving down [local street]. [Police Officer] got out with the three runaway juveniles on the 4-wheeler ...Myself and [police officer] transported all three juveniles back to 245 Valleybrook Ln. I cleared all three juveniles from NCIC." Runaway Incident #8 Review on 1/20/22 of the IRIS revealed: - Date of Incident: 11/4/21 - Time of Incident: 7:50 pm - Consumer's name: FC #5 and FC #6 - Name of Person Completing this form: QP #3 - Staff (unknown which staff) ensured FC #5 that he would be allowed to have his nighttime snack after he completed his nightly hygiene routine. FC #5 reflected on his frustration with following the rules and regulations of the level III residential facility. Staff did a 15-minute safety check and noticed FC #5's window was open. Staff observed FC #5 and his peer (FC #6), were missing. Staff contacted the police. - Another entry in the IRIS report indicated that FC #5 and other clients (unknown which consumers) were found at another location. It is unknown which date and time FC #5 and FC #6 were found.	V 112		

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V 112	Continued From page 14 Review on 1/20/22 of the Police Report revealed: - Date/time reported: 11/4/21 at 19:11 (7:11 pm) - Name: FC #5 and FC #6 - "On 11/04/2021 responded to a runaway juvenile at 245 Valleybrook Ln around 1900HRS (7:00 pm). Myself and [police officer] checked the area for approx. 30 min and was unable to locate the subjects. A caller then called in advising the two juveniles ran behind [local restaurant] headed towards [local fire department]. I checked on foot behind same unable to locate. Both juveniles have been entered NCIC along with clothing description. No further information ...on 11/7/21 at 1320 HRS (1:20 pm) ECOM (emergency communications) advised for me to call in reference a hit confirmation on [FC #5] where same was located by [nearby police department]. Confirmed to ECOM, and [nearby police department] did the locate on [FC #5]. [FC #6] is still missing." Runaway Incident #9 Review on 1/20/22 of the IRIS revealed: - Date of Incident: 11/26/21 - Time of Incident: 7:45 pm - Consumer's name: client #1 - Name of Person Completing this form: QP #3 - Client #1 had become upset and triggered by his peers. Client #1 started cursing and arguing with staff regarding his desire to leave the group home. Client #1 packed up his bag and stated he was leaving the group home. Client #1 refused to remain in his assigned area and walked out the front door. Staff (unknown which staff) contacted the police. Police came to the group home. Later client #1 returned to the group home on his own and the police were notified that client #1 had returned. It is unknown what time client #1 returned to the facility.	V 112		

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V 112	Continued From page 15 Runaway Incident #10 Review on 1/20/22 of the IRIS revealed: - Date of Incident: 12/11/21 - Time of Incident: 1:00 am - Consumer's name: FC #5 - Name of Person Completing this form: QP #3 - "Staff prompted [FC #5] to prepare for the remainder of the day. Staff commended [FC #5] for walking away when expressing his frustration with his peers. Staff actively listened to [FC #5] express how he becomes irritated when his peers interrupt him when he's speaking. Staff attempted to role play with [FC #5] on how to redirect his negative thoughts and emotions when feels angry and frustrated emotionally and mentally. Staff praised [FC #5] for redirecting his negative thoughts and emotions prior to completing his nightly hygiene routine. [FC #5] agreed to ask for further assistance from staff when necessary. Staff prompted [FC #5] to remain in his assigned area and to abide by the group home rules and regulations. [FC #5] stated he was still upset and didn't feel like remaining in his designated area. Staff processed with [FC #5] on utilizing his coping skills such as deep breathing and journaling any negative thoughts and emotions. Staff commended [FC #5] for retiring to his designated area for the remainder of the night. Staff conducted 15-30-minute safety checks to ensure the safety of [FC #5]. Staff continued to check on [FC #5] every 15-30 minutes for safety. Staff went into [FC #5]'s designated area to ensure he was safe and [FC #5]'s window was opened. [FC #5] left out of the window without staff's permission. Staff contact [Local Law Enforcement] to report [FC #5] missing. Staff contacted [FC #5's] Guardian to make her aware	V 112		

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V 112	Continued From page 16	V 112		

of the missing person's report. Officer came and to gather additional documentation in order to identify [FC #5]. [Police Officer] contacted to inform the group home that [FC #5] stole a car from someone's home and drove the car to [city] where [FC #5] caught a flat tire. [Police Officer] also stated [FC #5] was most likely not alone anymore. [Nearby police department] contacted the group home and reported [FC #5]was with someone crossing the street and the other person was hit by a car and reported [FC #5] was questioned by a police officer and [FC #5] provided false information to the officer. The officer looked up some information and saw that both [FC #5] and the person hit by the car was reported missing. [Police Officer] stated that [FC #5] ran away and they could not find him therefore there was no longer a request to come pickup [FC #5]. Staff was contacted by an anonymous tip to pick up [FC #5] from a hotel near the [local shopping mall]. Staff picked up [FC #5] and accompanied him to [local hospital] for psychiatric evaluation. [Local Hospital] released [FC #5] stating he was not a danger to anyone nor himself."

Review on 1/14/22 of the Police Report revealed:
- Date/time reported: 12/11/21 at 0:53 (12:53 am)
- Name: FC #5
- "On 12/11/21 responded to a runaway juvenile at 245 Valleybrook Lane around 0050HRS (12:50 am). [Police officer #1] and [police officer] responded to the area and checked same for about 30 minutes unable to locate the offender (FC #5). The offender was last seen around 0030HRS (12:30 am) at 245 Valleybrook Ln. The offender will be entered in NCIC along with what he was last wearing. No further information at this time."
- "On 12/12/21 around 11:04 a.m. I was

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V 112	Continued From page 17 dispatched to a speak with officer in reference to [FC #5] the runaway from Miracle House. I then made contact with [FC #5's mother] ... [FC #5's mother] stated that she had been contacted by [staff #2] who is one of the councelors from the facility. [FC #5's mother] said [staff #2] told her he had been contacted by an officer with [second police department] (37 miles away) told him he had made contact with [FC #5] but let him go. [FC #5's mother] asked me if we had done a missing person report and I advised her we had. [FC #5's mother] said she didn't understand why the officer let [FC #5] go. I told [FC #5's mother] I would try and find out. - "I then made contact with [staff #2] who told me that he had spoken with a [second police department's] officr around 10:30 p.m. who told him [FC #5] was in [city]. [Staff #2] did not remember the officer's name and didn't have his phone number. [Staff #2] told me about the officer making contact with [FC #5] and [FC #5] not giving him the correct information of his identity. The officer was unable to identify him at that time and is why he didn't take custody of him. I then asked communications to contact [a second police department] to have an officer contact me. I was later contacted by [police officer] who was the officer that had made contact with [FC #5]. [The police officer] stated that [FC #5] and another runaway female was crossing the a highway to get to the mall when the female was struck by a car. [The police officer] said that when he was investigating the incident, [FC #5] gave him the incorrect spelling of his name. [The police officer] told me that when he was questionoing [FC #5] more he got upset and then ran off. [The police officer] stated at that point he had not identified him so he did not pursue. [The police officer] said that [FC #5] had said they were trying to ge to the motel in which [the police officer] later	V 112		

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checked. [The police officer] told me that the clerk told him that she had seen him earlier but did not know where he was. [The police officer] stated that he looked for him in the area but he didn't find him. Unkown how [FC #5] got to [city] (37 miles away) or his location at this time."
- "On 12/13/2021, I was notified by [staff #2], Miracle House staff member, that [FC #5] was back in town and was at [hospital], in behavioral health. [Staff #2] was going to try and get an IVC (Involuntary Commitment] order for [FC #5] and have them hold him for at least 48 hours ... According to [staff #2], he found him at a motel across from [local mall], and transported him back to town."
- "On December 13, 2021 [police officer] contacted by [staff #2] and [staff #2] advised he had [FC #5] in his custody and was taking him to [local hospital]. I made contact with [local hospital] and the charge nurse advised me [FC #5] was released into the custody of the group home. I had [police officer] go by the group home at 245 Valley Brook Lane to verify [FC #5] was there. [FC #5] was at the home and under the care of staff. This report is closed and [FC #5] has been cleared from NCIC."

Review on 1/14/22 of the Police Report revealed:
- Date/time reported: 12/11/21 at 8:33 am
- Name: FC #5
- "On 12/11/21 around 8:33 a.m. I was dispatched to [local tire company] in reference to larceny of a truck. Upon my arrival I spoke with [the business owner] of the company and the truck. [The business owner] stated that he was contacted this morning by [highway patrol]. [The business owner] said the trooper told him she had located a truck on the side of [interstate] in [local city] that was registered to his company. [The business owner] told me the Trooper said the truck had

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V 112	Continued From page 19 some damage on it and was wanting to know why it was at that location. [The business owner] stated he told the Trooper that it shouldn't be there and that it must have been stolen. [The business owner] then contacted 911 and advised them of the situation." - "[The business owner] then pulled up his video from his surveillance cameras. The truck was parked in front of one of the cameras. Around 1:04 a.m. a subject wearing a grey in color hoodie, dark pants, white in color tennis shoes, with a book bag on his back is seen walking up and entering the vehicle. The subject sat inside the truck for a while and appeared to be trying to figure out how to operate it. The subject then figured out how to drive the vehicle forward. The subject moved the vehicle forward several feet the stopped. The subject then got out and ran back toward the building. The subject then reappeared carrying a large duffle bag. The subject got back inside the truck and began backing up and is seen leaving the area." - "On one of the other surveillance cameras the subject can be seen a lot clearer and can be identified as [FC #5]. [FC #5] is a thirteen year old black male that was reported as a runaway around 12:30 a.m. from the Miracle House. I then went to that location and spoke to one of the councelors. I asked what [FC #5] had taken when he left. The councelor stated his clothes in a large duffle bag. I then asked the councelor to go back to the scene to watch the surveillance video. We then retuned to the location and after watching the video the councelor stated that it was definitely [FC #5]...There was damage to the right rear of the truck and a small scratch on the left side ..." Runaway Incident #11	V 112		

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V 112	Continued From page 20 Review on 1/20/22 of the IRIS revealed: - Date of Incident: 12/17/21 - Time of Incident: 8:30 pm - Consumer's name: client #1 - Name of Person Completing this form: Former QP - Client #1 was being prompted by staff (unknown which staff) to remain in his assigned area. Client became defiant and ran outside, and staff followed him until he went into the woods. Staff contacted the police and the police brought back client #1 about an hour and half later. Runaway Incident #12 Review on 1/11/22 of the IRIS revealed: - Date of Incident: 12/18/21 - Time of Incident: 4:00 pm - Consumer's name: client #1 - Name of Person Completing this form: Administrative Assistant - Client #1 was found with tobacco products "that were from staff's (unknown which staff) backpack." Client #1 got upset when questioned about how he got the tobacco products. - "After staff was able to obtain the tobacco products, staff placed the tobacco products back safely in his backpack within the vehicle and locked it away safely." - Client #1 later became upset and ran out the back door. The police were called and the police returned client #1 to the group home "hours" later. Review on 1/14/22 of the Police Report revealed: - Date/time reported: 12/18/21 at 16:34 (4:34 pm) - Name: client #1 - "On 12/18/21, I and [police officer] responded to 245 Valley Brook Lane, in reference to a missing runaway. I was notified [client #1] had run off five	V 112		

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minutes prior to my getting the call. [Police officer] and I searched the area but was unable to locate [client #1]. 12/19/2021 09:22 (9:22 am) [client #1] was located on (road) earlier this morning by [local sheriff's office] ..."

Runaway Incident #13

Review of the IRIS on 1/20/22 revealed no report of an incident involving FC #5 and client #1 on 12/19/21.

Review on 1/14/22 of the Police Report revealed:
- Date/time reported: 12/19/21 at 15:15 (3:15 pm)
- Names: FC #5 and client #1
- "On 12-19-21 at 1515 HRS (3:15 pm) The employees of the miracle houses stated that [client #1] and [FC #5] left the facility and was on foot. [Police Officer] and myself noticed the subjects walking at the corner of [street name] and [street name]. I immediately noticed that [FC #5] was bouncing around and in the thinking process of running while [client #1] was walking down at a steady pace. [Police officer] attempted to get control of [FC #5] but same got around [police officer] and began running in the back yards of [street]. I drove around to [street] and got out of the car and began chasing [FC #5]. [FC #5] ran behind [street] and I noticed him to be getting winded. I apprehended [FC #5] in the bottom of the hill at [street] with the help of an employee from the group home ...placed [FC #5] in handcuffs to ensure that he would not run again ...I escorted [FC #5] back to the group home where he kept asking me where my warrant was and he kept calling me racial slur. I left [FC #5] at the house and attempted to look for [client #1] at this time ....12/19/2021 18:20 (6:20 pm) On todays date [client #1] returned to the home on his own accord and was cooperative. Rather than

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calling us, a female worker (unknown group home staff) brought him to the PD (police department) and wanted us to search him and transport him to the hospital for an IVC. [Client #1] was cooperative and gave us no issues. I explained to the female (unidentified facility staff) we were not going to transport [client #1] since he was cooperative and not causing an issue. She was unhappy with my answer, but eventually transported [client #1] in her vehicle. This is the same female expecting us to transport juveniles every time. She is also the same one that has runaways nearly every day she works ..."

Runaway Incident #14

Review on 1/11/22 of the IRIS revealed:
- Date of Incident: 12/20/21
- Time of Incident: 5:45 pm
- Consumer's name: FC #5
- Name of Person Completing this form: Administrative Assistant
- "[FC #5] was prompted to complete his evening hygiene routine as scheduled for the end of the day. [FC #5] came out of the bathroom and just threw his soiled clothing and linen on the hallway floor. [FC #5] was prompted by staff to pick his items up off the floor and was then observed packing his bookbag. Staff attempted to process with [FC #5] to find out what was wrong with him but he refused to respond. Staff continued to try and process to find out what was going on with [FC #5]. [FC #5] then proceeded to walk out of the front door. Staff followed [FC #5] while trying to process with him but he proceeded to run. AWOL protocol was followed at that time. [Local police] officers returned with [FC #5] later in the middle of the night around 1am. Executive Director requested that staff transport [FC #5] to [local hospital] where he jumped out of the car

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and ran. Staff again called to make another report of the missing [FC #5]. On 12/21/2021 [local police] reached out to Executive Director to have her meet with them in [local city] to turn [FC #5], they stated that [FC #5] had stolen a car and possible damage to stolen vehicle. [FC #5] has been admitted at [local hospital] for evaluation and is to be released to his foster Parent when he has completed his treatment with [local hospital]."

Review on 1/20/22 of the IRIS revealed:
- Date of Incident: 12/20/21
- Time of Incident: 5:45 pm
- Consumer's name: client #1
- Name of Person Completing this form: Administrative Assistant
- Staff (unknown which staff) was processing with a peer who was trying to go AWOL and client #1 walked through the neighbor's back yard. Staff followed client #1 until client #1 was out of sight. Police were called and consumer returned to the facility on the same day. It is unknown what time client #1 returned to the facility.

Review on 1/20/22 of the police report revealed:
- Date/time reported: 12/20/21 18:01 (6:01 pm)
- Name: FC #5 and client #1
- "On 12/20/2021 Myself and [Police Officer] responded to the area of 245 Valleybrook Ln (Lane). We checked the area for approx. 20 min. (minutes) when [police officer] located [client #1] one of the runaways behind [local business], [police officer] transported [client #1] back to 245 Valleybrook while I continued to look for the offender (FC #5). I checked all known business in the area. [Police officer] gained info that the offender might be located near the [local Pub]. Myself and [police officer] checked same, but was unable to locate same. There was beer bottles where they have been there before. The offender

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is entered into NCIC along with a BOLO (Be On the Look Out) sent out. No further information at this time ....12/20/21 22:31 (10:31 pm): On 12/20/21 around 2200HRS (10:00 pm) [neighboring police department] advised they had located offender (FC #5) with the [client #1] subject. The two was located in a vehicle they took from [local road] in [local city]. [Neighboring police department] detained the two and held them at there police department until the group home picked them up. [Neighboring police department] sent the locate and he has been taken out of NCIC."

Runaway Incident #15

Review on 1/20/22 of the IRIS revealed:
- Date of Incident: 1/15/22
- Time of Incident: 7:55 pm
- Consumer's name: client #1
- Name of Person Completing this form: QP #3
- "On 1.15.22 at 7:45 pm. After administering medication and showering, Consumer #102926 (client #1) transitioned to his assigned area for the night but was later discovered to have gone AWOL."
- Staff (unknown which staff) went into client #1's bedroom and noticed his window was open. Staff saw client #1 walking up the street and staff called out for him. Client #1 then started running towards the woods and the police were called. While client #1 was away from the group home, he stole from a local store.
- Client #1 returned to the group home on his own.

Interview on 1/12/22 with the Licensee revealed:
- She attempted to prevent FC #5 from running by discussing in staff meetings keeping eyes on FC #5. She also used incentives and telephone calls

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V 112	Continued From page 25 to FC #5's mother as an intervention to prevent FC #5 from running away because FC #5's mother could calm him down. Interview on 1/24/22 with the Licensee revealed: - The strategies the staff used with FC #5 to prevent AWOLs: extra staff, put a chair at his door, process with him, incentives to earn money/purchase items. - The staff used the strategy of taking FC #5's shoes and extra clothes to prevent AWOLs but she stopped allowing this to be used because in the past a MCO (Managed Care Organization) had cited her for taking another client's shoes. - The staff used the same strategies with FC #6 as she used with FC #5. Additionally, with FC #6 she used "stop and think" strategies. - The strategies the staff used with client #1 to prevent AWOLS: incentives, giving him rewards, going on outings with certain staff and walking in the woods with staff. Interview on 1/13/22 with FC #5 revealed: - One time staff took his shoes and extra clothes and that prevented him from running. - Then later, staff gave him back his clothes and shoes and he started running again. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides	V 293		

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V 293	Continued From page 26 intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.	V 293		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to provide treatment to minimize the occurrence of behaviors and failed to ensure supervision and safety, affecting 1 of 4 current clients (client #1) and 2 of 2 former clients (FC #5 and FC #6). The findings are:

Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on records review and interviews, the facility failed to develop and implement strategies affecting 1 of 4 current clients (#1) and 2 of 2 former clients (FC #5 and FC #6).

Review on 1/21/22 of the Plan of Protection dated 1/21/22 written by the Licensee revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The plan of protection will take place effectively today January 21, 2022.
Miracle Houses will adhere to the AWOL policy when a consumer has gone awol (2 to 3 times) Miracle Houses Inc will continue to submit a 10-day health and safety discharge and a 30-day discharge to the MCO and the guardian and follow through with the discharge. Also, when the guardian refuses to pick up their child, Miracle Houses Inc. will file a complaint with the local

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V 293	Continued From page 28 Department OF SOCIAL SERVICES AND REPORT A NEGLECT CHARGE. Miracle Houses will continue to ensure that strategies are put in place in the Child's Person Center Plan to address their present behaviors and prehistory behaviors. Miracle Houses Inc. will continue to meet with staff prior to being admitted to ensure that staff is receptive and understand consumer needs. Miracle Houses Inc. will continue to communicate with the child's guardian from admission to the discharge." The facility served former and current clients with various diagnoses not limited to: Attention Deficit Hyperactivity Disorder, Conduct Disorder, Disruptive Mood Dysregulation Disorder, Anxiety Disorder, Intellectual Disability, and Cannabis Use Disorder. The clients had a history of: lying, stealing, setting fire in a home, AWOL behaviors, physical aggression, hitting and choking family members, property destruction and inappropriate sexual behavior. During the time period between 9/11/21-1/15/22, there were 15 different incidents of AWOL. During one AWOL incident, FC #5 who was 13, was gone for two days, stole a truck, drove the truck over a hour away and the truck was hit while he was driving it. There was another runaway incident involving FC #5 and client #1 who were found by the police in a stolen car. During another runaway incident involving FC #5 and FC #6, FC #5 was found 3 days later, and FC #6 was still missing on day 3. Multiple Law Enforcement agencies have been involved in the AWOL incidents. While treatment plans identified AWOL behaviors for these clients, there were never any strategies developed or implemented to address the ongoing and dangerous AWOL behaviors.	V 293		

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V 293	Continued From page 29 This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $5,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 293		
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 and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present	V 296		

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V 296	Continued From page 30 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 record review and interviews, the facility failed to ensure 1 of 2 former client's (FC #5) individualized needs were provided as specified in the treatment plan. The findings are: Review on 1/11/22 of FC #5's record revealed: - Admission date: 8/16/21 - Discharge date: 12/22/21 - Age: 13 - Diagnoses: ADHD (Attention Deficit Hyperactivity Disorder), Combined type and Conduct Disorder - Review of FC #5's Person Centered Profile (PCP) dated 12/14/21 revealed: " ...will learn and develop positive coping skills ...in order to manage his aggressive behaviors evidenced by a reduction in physical and verbal aggression toward others and marked improvement with the	V 296		

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utilization of positive coping skills to decrease symptoms of irritability 4:7 days per week for six months and AWOL (absent without leave) behaviors ...Master Level Qualified Professional (QP) will provide one on one staffing to prevent AWOL behaviors."
- Review of FC #5's discharge plan: "Reason for Discharge: ...[FC #5] displayed AWOL weekly."

Review on 1/11/22 of the Incident Response Improvement System (IRIS) revealed:
- Date of Incident: 12/20/21
- Time of Incident: 5:45 pm
- Consumer's name: FC #5
- Name of Person Completing this form: Administrative Assistant
- FC #5 walked out the front door and went AWOL at 5:45 pm. The report did not indicate which staff were present during this incident. An unknown staff followed FC #5 and FC #5 started to run. The local police were called by unknown staff and the local police returned FC #5 to the group home around 1:00 am. The Licensee instructed staff to transport FC #5 to the local hospital where he jumped out of the car and ran again. While FC #5 ran again he stole a car and there was "possible damage" to the stolen car.

Review on 1/20/22 of the police report revealed:
- Date/time reported: 12/20/21 18:01 (6:01 pm)
- Name: FC #5 and client #1
- "On 12/20/2021 [police officer #1]and [Police Officer] responded to the area of 245 Valleybrook Ln (Lane). We checked the area for approx. (approximately) 20 min. (minutes) when [police officer] located [client #1] one of the runaways behind [local business], [police officer] transported [client #1] back to 245 Valleybrook while I continued to look for the offender (FC #5). I checked all known business in the area. [Police

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officer] gained info (information) that the offender might be located near the [local Pub]. Myself and [police officer] checked same, but was unable to locate same. There was beer bottles where they have been there before. The offender is entered into NCIC (National Crime Information Center) along with a BOLO (Be On the Look Out) sent out. No further information at this time ....12/20/21 22:31 (10:31 pm): On 12/20/21 around 2200HRS (10:00 pm) [neighboring police department] advised they had located offender (FC #5) with the [client #1] subject. The two was located in a vehicle they took from [local road] in [local city]. [Neighboring police department] detained the two and held them at there police department until the group home picked them up. [Neighboring police department] sent the locate and he has been taken out of NCIC."

Review on 1/14/22 of "Employee Timesheet Work Log" dated 12/20/21 revealed:
- Two staff had signed in on 12/20/21 for second shift: QP #2 and staff #1.
- The QP #2 signed in from 3:00 pm-9:47 pm
- Staff #1 signed in from 2:30 pm-11:47 pm
- Staff #3 did not sign in on 12/20/21.

Review on 1/14/22 of staff #1"s December 2021 time sheet revealed:
- On 12/2021 she worked from 6:50-11:45 (am or pm was not documented) at Miracle Houses Valley Brook I.

Review on 1/14/22 of staff #3's December 2021 time sheet revealed:
- On 12/20/21 she worked from 1:15-8:15 (am or pm was not documented) but not at Miracle Houses Valley Brook I.
- The group home listed on staff #3's December 2021 time sheet is a different group home owned

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V 296	Continued From page 33 by the Licensee. Review on 1/14/22 of the QP #2's December 2021 time sheet revealed: - On 12/20/21 she worked from 1:45-9:45 (am or pm was not documented) Interviews on 1/13/22 and 1/18/22 with FC #5 revealed: - During the month of December 2021 there would be two staff who worked from when he woke up until he went to bed. The night shift started at 8 pm and there were 1 or 2 staff who worked at night. - He did not have a "one on one" staff person who supervised him. - On 12/20/21 he ran 3 times. - The first time he ran on 12/20/21 he ran by himself and QP #2 and staff #1 were working. He ran around 5-6 pm and the sheriff's department brought him back. - The second time he ran on 12/20/21 he ran with client #1. Staff #8 was the only staff working when he ran. He got picked up by the local police department. When he was brought back by the police, staff #7 drove over to assist staff #8 with driving him to the behavioral health hospital. - He ran the 3rd time on 12/20/21 once he arrived at the behavioral health hospital. He found a car with the keys in it across the street from the hospital and drove the stolen car until he was found by the local sheriff deputy. Once he was found by the sheriff deputy, he pulled the stolen car over. The sheriff deputy put him in handcuffs until the Licensee met him and drove him back to the behavioral health hospital. Interview on 1/14/22 with the QP #2 revealed: - She or staff #2 acted as FC #5's one on one staff.	V 296		

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- She could not recall the exact time that FC #5 ran on 12/20/21, "it was second shift."
- She felt that FC #5 "was fine" and "not triggered" prior to running.
- On 12/20/21, FC #5 threw his dirty clothes and towel outside the bathroom door and she prompted him to pick it up. He then started packing items in his backpack, put on his coat and went out the door. She followed FC #5 outside but he got away from her and she called 911. Staff #1 and staff #3 were also working.
- There are no alarms on the windows because the clients kept taking the alarms off the windows.
- "I am not sure why [FC #5] was running."

Interview on 1/13/22 with staff #2 revealed:
- He was not sure which staff was FC #5's one on one staff.
- He was not aware that FC #5's treatment plan had indicated FC #5 needed one on one staffing.

Interview on 1/14/22 with staff #8 revealed:
- Staff #9 worked with him on 12/20/21.
- When FC #5 ran the first time on 12/20/21, two staff were present: QP #2 and staff #1.
- On 12/20/21 after FC #5 ran the first time, he then came on shift and picked up FC #5 from the local police department around 8:30 pm.
- Once FC #5 was brought back to the group home, he ate and then ran away again. "He walked out the back door." He called the police and the police brought FC #5 back to the group home.
- He and staff #9 drove FC #5 to the hospital.

Interview on 1/14/22 with staff #9 revealed:
- She started working at the group home 12/9/21 and since she started, there had always been 2 staff who worked her shift.
- She worked 3rd shift on 12/20/21 and recalled

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V 296	Continued From page 35 FC #5 running. FC #5 ran before she started her shift at 11 pm. When she came in at 11 pm, the police were there. - On 12/20/21, she worked 3rd shift with staff #8. On 12/2021, 2nd shift had two staff who worked but due to being a new employee she could not remember the names of the two staff who worked before her shift on 12/20/21. Interview on 1/18/22 with staff #1 revealed: - During the month of December 2021 there were always 2 or 3 staff who worked each shift. It was more often 2 staff. - On 12/20/21, she worked with the QP #2 and staff #3 on 2nd shift (2:00 pm or 3:00 pm until 11:00 pm). On 12/20/21, FC #5 and client #1 ran during 2nd shift and the police were called. This occurred right after FC #5 took a shower around 6:00 pm. FC #5 and client #1 were found by the neighboring police department in a stolen car. - Staff #8 and staff #9 worked the 3rd shift on 12/20/21. - Staff #8 took FC #5 to the behavioral health hospital after FC #5 ran the second time. When FC #5 arrived at the behavioral health hospital, FC #5 got out of the car and ran again. - Staff #2 and the Licensee were FC #5's one on one staff. Interview on 1/19/22 with staff #3 revealed: - She worked on 12/20/21 she thought on 2nd shift. - She recalled working with the QP #2 and another staff. She recalled QP #2 trying to chase FC #5 when he was running. - She could not recall the time she worked on 12/20/21 because she worked different group homes. - "We don't have a certain time we work. My 2nd shift could start at any time."	V 296		

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V 296	Continued From page 36 Interviews on 1/14/22, 1/18/22 and 1/24/22 with the Licensee revealed: - In December 2021, the one on one for FC #5 was staff #2. FC #5 "would call [staff #2] if he needed him but he really didn't need that (one on one staff)." - "I didn't think [FC #5] needed a one on one during the 3rd shift." - She had put alarms on the group home windows twice: one time a year ago and then one time right before the summer 2021. The clients pulled the alarms off. - The group home time sheets were not accurate becuase staff did not always sign in. This deficiency constitutes a re-cited deficiency This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Failure to Correct Type A1.	V 296		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the	V 367		

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	MHL049-155	A. BUILDING: _____ B. WING _____	R-C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRACLE HOUSES VALLEY BROOK I	245 VALLEY BROOK LANE TROUTMAN, NC 28166

(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 367	Continued From page 37 Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 38 becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report all Level II incidents that occurred during the provision of billable services to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. The findings	V 367		

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V 367	Continued From page 39 are: Review on 1/14/22 of the Police Report revealed: - Date/time reported: 12/19/21 at 15:15 (3:15 pm) - Names: FC #5 and client #1 - "On 12-19-21 at 1515 HRS (3:15 pm) The employees of the miracle houses stated that [client #1] and [FC #5] left the facility and was on foot. [Police Officer] and myself noticed the subjects walking at the corner of [street name] and [street name]. I immediately noticed that [FC #5] was bouncing around and in the thinking process of running while [client #1] was walking down at a steady pace. [Police officer] attempted to get control of [FC #5] but same got around [police officer] and began running in the back yards of [street]. I drove around to [street] and got out of the car and began chasing [FC #5]. [FC #5] ran behind [street] and I noticed him to be getting winded. I apprehended [FC #5] in the bottom of the hill at [street] with the help of an employee from the group home ...placed [FC #5] in handcuffs to ensure that he would not run again ...I escorted [FC #5] back to the group home where he kept asking me where my warrant was and he kept calling me racial slur. I left [FC #5] at the house and attempted to look for [client #1] at this time ....12/19/2021 18:20 (6:20 pm) On todays date [client #1] returned to the home on his own accord and was cooperative. Rather than callings us, a female worker brought him to the PD and wanted us to search him and transport him to the hospital for an IVC. [Client #1] was cooperative and gave us no issues. I explained to the female we were not going to transport [FC #5] since he was cooperative and not causing an issue. She was unhappy with my answer, but eventually transported [FC #5] in her vehicle. This is the same female expecting us to transport juveniles every time. She is also the same one	V 367		

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V 367	Continued From page 40 that has runaways nearly every day she works ..." Review on 1/20/22 of the Incident Response Improvement System (IRIS) revealed: - There was no incident report regarding the 12/19/21 incident of client #1 and FC #5 running away. Interview on 1/24/22 with the Licensee revealed: - She did an incident report for the 12/19/21 incident but did it as a level 1.	V 367		