

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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}	<p>INITIAL COMMENTS</p> <p>A follow-up survey was completed on May 19, 2022. Deficiencies were recited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children or Adolescents</p> <p>The facility is licensed for 4 and currently has a census of 4.</p> <p>The survey sample consisted of 2 current clients and 1 former client.</p>	{V 000}		
{V 112}	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(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.</p>	{V 112}		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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}	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement strategies affecting one of two current clients (#2) and one of one former client (FC#1). The findings are:</p> <p>Review on 5/18/22 of Level II Incident Report dated 3/21/22 for FC#1 and Client #2 revealed: -"[Former Client #1] and [Client #2] eloped from house through bedroom windows. [Staff #3] requested to stay put in the house. [Staff #3] called police. [FC#1] and [Client #2] returned to the house on their own. Police came by to verify [FC#1's] and [Client #2's] return."</p> <p>Review on 5/18/22 of Level II Incident Report dated 4/4/22 for FC#1 and Client #2 revealed: -"[Staff #4] conducted night room checks and saw that [Client #2] was not in the bed. [Staff #4] called the police to report that [Client #2] was gone. [Staff #4] checked [Client #2's] bedroom and notice [Client #2's] ankle monitor was cut, and clothes were missing. [Client #2] eloped with [FC#1]. The police contracted the group home during the afternoon and stated that [Client #2] and [FC#1] had stolen a car and would go to detention."</p> <p>Review on 5/17/22 of Client #2's record revealed: -Age 14. -Sibling of FC#1.</p>	{V 112}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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}	<p>Continued From page 2</p> <p>-Admission date of 3/7/22.</p> <p>-Diagnoses of Post-Traumatic Stress Disorder and Conduct Disorder (Independent Psychological Assessment Addendum dated 2/24/22).</p> <p>-Probation status upon admission with Electronic Ankle Monitor.</p> <p>Review on 5/17/22 of Client #2's Addendum to Comprehensive Clinical Assessment dated 1/11/22 revealed:</p> <p>-"[Client #2's] criminal charges from 9/17/21-12/17/21 include felony possession of stolen motor vehicle (3), misdemeanor willfully resist, delay and obstruct arrest (2), felony larceny of motor vehicle, felony conspiracy to commit larceny of motor vehicle, felony breaking and entering, misdemeanor possession of stolen goods, and counts of robbery with a dangerous weapon. [Client #2's Guardian] voiced concerned with [Client #2] and his brother [FC#1] running away and refusing placement. [Client #2's Guardian] would like to see [Client #2] find stability in placement, however [Client #2's] previous behaviors and pending legal charges have impacted the team's ability to secure placement."</p> <p>Review on 5/17/22 of Client #2's Independent Psychological Assessment Addendum dated 2/24/22 revealed:</p> <p>- "...[Client #2] is in need of immediate placement and the recommendation remains a Level III group home based on medical necessity ..."</p> <p>Review on 5/17/22 of Client #2's Treatment plan dated 3/1/22 revealed the following goal:</p> <p>-"[Client #2] will comply with all rules and expectations in the group home setting, school and community 3 out of 7 days per week by:</p>	{V 112}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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}	<p>Continued From page 3</p> <p>-Refrain from (elopement/run away behaviors and any illegal activities)."</p> <p>-"How (support/intervention) - Residential Level III - Youth Builders Staff, Qualified Professional, Therapist will provide structured activities that promoted and encouraged social skills development, and which affords [Client #2] the opportunities for developing healthier relationships with peers and adults. Staff will implement and reinforce a behavioral management program that rewards positive behavior and consequences that are appropriate ..."</p> <p>-Treatment plans for Client #2 and FC#1 were identical.</p> <p>Review on 5/18/22 of the Shift Note from 12:00a.m.- 8a.m. dated 3/21/22 for Client #2 revealed: -"Intervention: -[Staff #3] arrived at the facility consumer was in the bed sleep. [Staff #3] did a room check at 3:30 a.m. and saw that [Client #2] was not in bed. [Staff #3] called the cops to report that [Client #2] was gone. [Client #2] didn't return until 6:30 a.m. [Staff #3] told [Client #2] to go to bed. [Staff #3] monitored [Client #2] the rest of the shift."</p> <p>Review on 5/18/22 of Client #2's Behavioral Plan (for Elopement) dated 3/23/22 revealed: -"Targeted Maladaptive Behavioral for Deceleration: -Elopement-any instance where [Client #2] leaves the group home premises without prior permission." -"Targeted Adaptive Behavior for Acceleration: -Functional Communication - requesting to have a one-on-one conversation with staff, taking time out (to his room to calm down), taking a walk with staff, exercising, deep breathing with</p>	{V 112}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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}	<p>Continued From page 4</p> <p>counting (to calm down) or [Client #2] needing/asking for interaction." -"Strategies: -Communicate with [Client #2] about what is bothering him. -Assist [Client #2] with identifying areas that he has made positive gains. -Remind [Client #2] of [Client #2's] goals that [Client #2] is working towards. -Encourage coping techniques to calm down. -Provide [Client #2] with support and reassurance. -Prompt [Client #2] to return to the group home." -Monitor [Client #2] keeping him in eye's view and arms reach, encourage calming strategies (deep breathing and counting, taking a time out, drawing, writing, walking with [Client #2] to get fresh air, and exercising (sit ups, push-ups, leg lunges and jumping jacks)." -Behavior Plan (for Elopement) for Client #2 and FC#1 were identical.</p> <p>Review on 5/18/22 of the Shift Note from 12:00 a.m.-8a.m. dated 4/2/22 for Client #2 revealed: -"Intervention: [Staff #4] arrived at the facility [Client #2] was in the bed sleep. [Staff #4] did a room check at 1:45 a.m. and saw that [Client #2] was not in bed. Staff called the police to report that [Client #2] was gone, [Client #2] didn't return. [Staff #4] went over [Client #2's] room and notice that [Client #2] monitor was cut off also and [Client #2's] clothes was missing as well."</p> <p>Review on 5/18/22 of FC#1's record revealed: -Age 15. -Sibling of Client #2. -Admission date of 3/7/22. -Diagnoses of Major Depressive Disorder,</p>	{V 112}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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}	<p>Continued From page 5</p> <p>Moderate, Conduct Disorder, Childhood Onset Type, Cannabis Use Disorder, Moderate, in Early Remission and Other Specified Trauma and Stressor Related Disorder (Independent Psychological Assessment dated 2/24/22). -Probation status upon admission with Electronic Ankle Monitor. -Discharged 4/4/22.</p> <p>Review on 5/18/22 of FC#1's Addendum to Comprehensive Clinical Assessment dated 1/11/22 revealed: -" ...[FC#1's] pending criminal charges from 9/17/21-12/17/21 include felony possession of stolen motor vehicle (3), misdemeanor willfully resist, delay and obstruct arrest (3), felony flee and elude, felony larceny of motor vehicle, felony conspiracy to commit larceny of motor vehicle, felony breaking and entering, felony conspiracy breaking and entering, felony larceny after breaking and entering, and counts of robbery with a dangerous weapon. [FC#1's Guardian] voiced concerned with [FC#1] and his brother [Client #2] running away and refusing placement. [FC#1's Guardian] would like to see [FC#1] find stability in placement, however [FC#1's] previous behaviors and pending legal charges have impacted the team's ability to secure placement."</p> <p>Review on 5/18/22 of FC#1's Independent Psychological Assessment Addendum dated 2/24/22 revealed: - "...[FC#1] is in need of immediate placement and the recommendations remains a Level III group home based on medical necessity ..."</p> <p>Review on 5/17/22 of FC#1's Treatment plan dated 3/2/22 revealed the following goal: -"[FC#1] will comply with all rules and expectations in the group home setting, school</p>	{V 112}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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}	<p>Continued From page 6</p> <p>and community 3 out of 7 days per week by: -Refrain from (elopement/run away behaviors and any illegal activities)." -"How (support/intervention) - Residential Level III - Youth Builders Staff, Qualified Professional, Therapist will provide structured activities that promoted and encouraged social skills development, and which affords [FC#1] the opportunities for developing healthier relationships with peers and adults. Staff will implement and reinforce a behavioral management program that rewards positive behavior and consequences that are appropriate ..." -Treatment plans for FC#1 and Client #2 were identical.</p> <p>Review on 5/18/22 of the Shift Note from 12:00 a.m.-8a.m. dated 3/21/22 for FC#1's revealed: -"Intervention: -[Staff #3] arrived at the facility consumer was in the bed sleep. [Staff #3] did a room check at 3:30 a.m. and saw that [FC#1] was not in bed. [Staff #3] called the cops to report that [FC#1] was gone. [FC#1] didn't return until 6:30 a.m. and told [Staff #1] [FC#1] was in the bathroom for 3 hours. [Staff #3] told [FC#1] to go to bed. [Staff #3] monitored [FC#1] the rest of the shift."</p> <p>Review on 5/18/22 of FC#1's Behavioral Plan (for Elopement) dated 3/23/22 revealed: -"Targeted Maladaptive Behavioral for Deceleration: -Elopement-any instance where [FC#1] leaves the group home premises without prior permission." -"Targeted Adaptative Behavior for Acceleration: -Functional Communication - requesting to have a one-on-one conversation with staff, taking time out (to his room to calm down), taking a walk</p>	{V 112}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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}	<p>Continued From page 7</p> <p>with staff, exercising, deep breathing with counting (to calm down) or [FC#1] needing/asking for interaction." -"Strategies: -Communicate with [FC#1] about what is bothering him. -Assist [FC#1] with identifying areas that he has made positive gains. -Remind [FC#1] of [FC#1's] goals that [FC#1] is working towards. -Encourage coping techniques to calm down. -Provide [FC#1] with support and reassurance. -Prompt [FC#1] to return to the group home." -Monitor [FC#1] keeping him in eye's view and arms reach, encourage calming strategies (deep breathing and counting, taking a time out, drawing, writing, walking with [FC#1] to get fresh air, and exercising (sit ups, push-ups, leg lunges and jumping jacks)." -Behavior Plan (for Elopement) for Client #2 and FC#1 were identical.</p> <p>Review on 5/18/22 of the Shift Note from 12:00 a.m.-8a.m. dated 4/2/22 for FC#1's revealed: -"Intervention: [Staff #4] arrived at the facility [FC#1] was in the bed sleep. [Staff #4] did a room check at 1:45 a.m. and saw that [FC#1] was not in bed. Staff called the police to report that [FC#1] was gone, [FC#1] didn't return. [Staff #4] went over [FC#1's] room and notice that [FC#1] monitor was cut and [FC#1's] clothes was missing as well.'</p> <p>Interview on 5/19/22 with Staff #3 revealed: -Worked with company for about 7 or 8 years. -There was always two staff on 3rd shift -He made rounds every 30 minutes. -He mostly sat in the living room or at the desk. -Other staff would usually sit in the same area.</p>	{V 112}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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}	<p>Continued From page 8</p> <ul style="list-style-type: none"> -There were alarms in the windows. -The clients broke the alarms when they eloped. -The current alarms were easy to remove. -They need better alarms. -FC#1 and client #2 left out the window. -The police returned FC#1 and client #1 back to the group home. <p>Interview on 5/19/22 with Staff #4 revealed:</p> <ul style="list-style-type: none"> -He mainly worked 3rd shift on the weekend. -Most of the time he worked 2nd shift -He did room checks every 15 to 30 minutes .He would change it up so clients would not get routine. -When he worked 2nd or 3rd shift, he sat at the end of the hall. -He was the person that put the chair at the end of the hall. -During 2nd shift if clients were in the common area the 2nd staff sat with the clients. -There were alarms on the windows. -"You could put something through the magnet so that the alarm did not go off or use a rubber band." -"They need to put alarms on the outside of the windows". -The alarms were on the inside of the window. -He encouraged management to get the alarms that would drill into the wall. <p>Interview on 5/17/22 and 5/18/22 with the House Manager revealed:</p> <ul style="list-style-type: none"> -Alarms were on the bedroom windows. -Clients knew how to remove them. -Clients removed the alarms on the windows "all the time." -They continued to use the same alarm company. -FC#1 and client #2 did not share rooms. -The front and back doors had security alarms that would beep. 	{V 112}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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}	<p>Continued From page 9</p> <ul style="list-style-type: none"> -Every 3rd shift staff did room checks every 30 minutes. -There were two staff per shift. -The alarm system was working. -Staff did not sit by client's bedrooms. -"The State did not say we should sit in the hall." -Staff sat in the living room and at the computer, near the dining room in view of the bedrooms. -Staff sitting in the living room and at the computer was not able to see what clients were doing in their bedrooms. -"Client's doors were not allowed closed; they were allowed to crack it open." -There was no evidence staff conducted bed checks every 30 minutes during bedtime and 3rd shift. -There were no staff meetings or trainings after February 2022 since previous survey. <p>Interview on 5/19/22 with the Qualified Professional revealed:</p> <ul style="list-style-type: none"> -She was responsible for completing clients' treatment plan. -She usually met clients face to face about 2 weeks after admission. -She completed the behavior elopement plan on 3/23/22. -Confirmed the elopement plans were not individualized. -Confirmed the treatment plan goal was standard. -Going forward during the face to face meeting she would work with clients on strategies to prevent elopements. <p>Interview on 5/18/22 with the Program Coordinator revealed:</p> <ul style="list-style-type: none"> -FC#1 and client #2 were accepted and admitted to the group home on 3/7/22. -FC#1 and client #2 were siblings. -Confirmed there were no staff meeting or 	{V 112}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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 10 training after the elopements on 3/21/22 and 4/2/22. -She stated, "we talked to staff all the time." -The last staff meetings and trainings were in February 2022. -Staff was supposed to conduct 30-minute bed checks on 3rd shift. -There was no documentation that staff conducted 30-minute bed checks. -There were alarms on the windows in each bedroom. -There were no cameras in the common areas in the home to determine if staff conducted room checks. -FC#1 was discharged while in detention and back to his mother. -Client #2 asked for a second chance and returned to the group home after detention on 4/14/22. This deficiency is cross referenced into 10A NCAC 27G. 1701 Scope (V293) of reviewed deficiencies for failure to correct Type A1 rule violation.	{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 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.	{V 293}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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 293}	<p>Continued From page 11</p> <p>(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.</p> <p>(d) The children or adolescents served shall require the following:</p> <p>(1) removal from home to a community-based residential setting in order to facilitate treatment; and</p> <p>(2) treatment in a staff secure setting.</p> <p>(e) Services shall be designed to:</p> <p>(1) include individualized supervision and structure of daily living;</p> <p>(2) minimize the occurrence of behaviors related to functional deficits;</p> <p>(3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint;</p> <p>(4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and</p> <p>(5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting.</p> <p>(f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.</p>	{V 293}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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 293}	<p>Continued From page 12</p> <p>This Rule is not met as evidenced by: This rule is not met based on evidence by record reviews and interviews, the facility failed to develop and implement strategies affecting one of two current clients' (#2) and one of one former client (FC#1). The findings are:</p> <p>Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record reviews and interviews, the facility failed to develop and implement strategies affecting one of two current clients' (#2) and one of one former client (FC#1). The findings are:</p> <p>Review on 5/19/22 of the Plan of Protection written by the Owner dated 5/19/22 revealed: "What will you immediately do to correct the above rule violations in order to protect client from further risk or additional harm? -Develop interventions and/or strategies to keep the consumer safe, i.e., safety plan. -Staff will regularly review consumer goals. -Staff will review communication log daily. -Ongoing trainings on elopement and safety."</p> <p>"Describe your plans to make sure the above happens? -Development of an elopement goal and development of individualized strategies for each consumer to address the elopement, and other behaviors. -Video camera will be checked regularly to prevent elopements. -Will seek new alarm system to prevent elopements. -Elopement plans will be reviewed quarterly and make changes as needed.</p>	{V 293}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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 293}	<p>Continued From page 13</p> <ul style="list-style-type: none"> -A staff debriefing will be held for elopements. -Licensed Professional (LP) and/or Qualified Professional (QP) will provide trainings to staff address elopements. -Room checks will be conducted every 15 minutes. -QP will document that they have met with children and document behaviors. -Will seek trainer internally or externally to conduct ongoing trainings with staff in addressing elopements. Will try internally first. -Monthly governance meetings will be held with clients including staff to discuss consumer concerns, school, behaviors, etc. -Staff will be positioned in the house by shift to monitor clients. -Client doors will be open." <p>FC#1 is a 15-year-old male diagnosed with Major Depressive Disorder, Moderate, Conduct Disorder, Childhood Onset Type and Cannabis Use and his brother Client #2 is 14-year-old male diagnosed with Post-Traumatic Stress Disorder and Conduct Disorder. FC#1 and Client #2 were both on probation with electronic ankle monitors prior to and during admission. FC#1 and Client #2 eloped from the facility through their bedroom windows on March 21, 2022 and April 2, 2022. During the 1st elopement FC#1 and Client #2 returned on their own. The 2nd elopement FC#1 and Client #2 removed their electronic ankle monitors and were apprehended by the police. After the first elopement the facility failed to put any measures in place. The facility did not develop and implement strategies for the clients', there were no changes in the window alarm system even after clients' tampered with them, there was a lack of documentation of room checks and staff supervision and monitoring to minimize and/or prevent an elopement from</p>	{V 293}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER YOUTH BUILDERS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2423 MORNINGSIDE DRIVE BURLINGTON, NC 27217
--	---

(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 293}	Continued From page 14 occurring. The facility discharged FC#1 while in detention and accepted Client #2 back to the facility. 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 293}		