LUTHERAN SERVICES CAROLINAS

Response To Deficiencies/Moretz Manor

July 26, 2022

Id Prefix Tag V 367

Corrective Action:

On July 13th, 2022, Program Director [redacted] Executive Director [redacted] and Behavioralist [redacted] conducted a general meeting with staff to review the violations within Moretz Manor. The meeting covered issues with assessments, habilitation and service plans. The meeting also covered concerns with documentation, incident reporting and chain of command per the results of the survey. The meeting was to bring immediate awareness to the concerns mentioned.

On July 29th, 2022, Program Director, [redacted] will have a detailed clinical supervision meeting to address deadlines and timelines referencing proper submission of incident reports to the LME. The clinical supervision meeting will also address what qualifies as an incident that should be reported to the LME. The meeting will also discuss the chain of command on how an incident should be communicated amongst each other along with deadlines.

Once a month, the Program Director, [redacted] will have the incident reporting process as part of the clinical supervision meeting agenda.

[redacted] Program Director

[redacted] 26, July, 2022

Completion date:
8-10-2022

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	MHL032-621	A. BUILDING: _____ B. WING _____	R-C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORETZ MANOR	409 EBON ROAD DURHAM, NC 27713

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on July 12, 2022. The complaints were unsubstantiated (intake #NC00189700 and NC00190176). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and currently has a census of 3. The survey sample consisted of audits of 1 current client and 1 former client.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter	V 111	RECEIVED AUG 04 2022 DHSR-MH Licensure Sect	

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V 111	Continued From page 1 referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have strategies in place to address the needs and behaviors prior to providing services affecting one of one former client (FC #4). The findings are: Review on 7/7/22 of FC #4's record revealed: -Admission date of 5/18/22. -Diagnoses of Major Neurocognitive Disorder due to Traumatic Brain Injury with Behavioral Disturbance, Dementia, Moderate Intellectual or Developmental Disability, Constipation, Dyslipidemia, Seizure Disorder, Chronic Obstructive Pulmonary Disease, Vitamin D deficiency and Polydipsia. -Discharge date of 6/11/22. -Admission Application from the local Local Management Entity/Managed Care Organization (LME/MCO) dated 5/10/22-Person requesting services for FC #4 wrote "[FC #4] requires more care and close monitoring due to high elopement risk." -Discharge Progress note from psychiatric hospital dated 11/17/21- "[FC #4] had short-term memory impairment, impulsivity, intrusiveness,	V 111		

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V 111	Continued From page 2 emotional dysregulation and thought disorganization...His agitation triggers are usually due to his misunderstanding or forgetfulness around redirection...In addition, he is somewhat hard of hearing and would benefit from a hearing aid...His inability to modulate his emotional affect is as much a process of his head injury as is his short-term memory deficit." -There were no strategies to address FC #4's elopement from the facility. Review on 7/7/22 and 7/11/22 of facility records for FC #4 revealed: (1) Incident reports: -6/11/22-FC #4 eloped from the facility around 2:40 am. Staff tried to encourage him to stay inside. FC #4 grabbed and pushed staff out of the way. Staff called the local police department. A couple hours later the local police department returned to the facility stating FC #4 could not be located. A Silver Alert was issued for FC #4. Staff searched for FC #4 and found him at a grocery store about 6 miles away from the facility. FC #4 told staff he walked to the grocery store to apply for a job. -6/11/22-FC #4 eloped from the facility again around 3:53 pm. Staff followed FC #4 in the van. Staff tried to encourage and redirect FC#4 to get into the van, however he refused. The local police department was called around 5:30 pm for assistance. The local police department responded and took FC #4 to the local hospital. -6/4/22-"[FC #4] was manic and had a behavioral episode...[FC #4] then eloped on 6/4/22 at about 5 pm stating that he needed to go to the car dealership to buy a car and to rent his own house. Staff tried for over an hour driving slowly beside him trying to encourage him to get in the van and return to the group home but he refused...Staff	V 111		

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V 111	Continued From page 3 then had to have him IVC'd (Involuntary Commitment) and the police was called to take him to the hospital." -6/3/22-"[FC #4] eloped at 2 am today stating to staff that he didn't want to stay at the group home." -6/2/22-FC #4 eloped from the facility 5 times today. He started leaving the facility around 2 am. Each time FC #4 left the facility the police department was called to assist the staff in bringing him back to the facility. -5/18/22-[FC #4] eloped from the facility around 9:30 pm. Staff on duty was assisting another client when FC #4 left the facility. The police department was contacted to report FC#4 eloped from the facility. When the Police Officers found FC #4, "he seemed very manic." The Police Officers took him to the local hospital. (2) Local Police Department Reports and Calls for Service for FC #4: -6/11/22-Police Report-"At approximately 3:59 am, I responded to 409 Ebon Rd (Road) for a call of a missing person at risk...[Staff #2] stated that at approximately 2:45 am, she was in the living room at the location. [Staff #2] stated [FC #4] then walked into the room and began to walk toward the front door. [Staff #2] then stood and blocked [FC #4's] path to the doorway. [FC #4] then pushed [Staff #2] causing her to fall to the floor...[FC #4] left his group home at least 8 times since May 25, 2022. [FC #4] had been found previously by officers near [Name of six different roads/streets in the area]." -6/11/22-Police Report-"On 6/11/22 I responded to the area of 409 Ebon Rd (Road) in reference to a missing person. Lutheran Services (Licensee) Moretz Manor, an assisted living group home for elderly men with mental health conditions, had called at 4:19 pm to report that one of their	V 111		

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V 111	Continued From page 4 residents, [FC #4], had walked out of the residence and gone missing again approximately 30 minutes prior...Together with [Name of other Officer], I searched for [FC #4] in the area of Ebon Rd (Road). I located [FC #4] a mile and a half away [Name of road]. [FC #4] appeared sweaty and disoriented and stated that he was trying to walk to get a job...Lutheran Services were advised that [FC #4] would be transported to [Name of local hospital]..." -6/4/22-Call for Service at 8:37 pm-"Involuntary Commitment" -6/3/22-Call for Service at 1:25 am-"Missing Person at Risk" -6/2/22-Call for Service at 2:08 am-"Missing Person at Risk" -6/2/22-Call for Service at 5:04 am-"Missing Person" -6/2/22-Call for Service at 7:10 am-"Missing Person" -6/2/22-Call for Service at 8:54 am-"Missing Person" -6/2/22-Call for Service at 10:10 am-"Urgent Welfare Check" -5/29/22-Call for Service at 8:18 am-"Urgent Welfare Check" -5/25/22-Call for Service at 2:16 am-"Missing Person at Risk" -5/25/22-Call for Service at 6:10 am-"Missing Person at Risk" -5/18/22-Call for Service at 9:19 pm-"Crisis" (3) Discharge Summaries from local hospital: -6/4/22- Seen at local hospital Emergency Department (ED) for Agitation. FC #4's diagnosis was a behavior concern. -5/25/22 Seen at local hospital ED for Psychiatric Evaluation. FC #4's diagnosis was a behavior concern.	V 111		

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V 111	Continued From page 5 -Between May 18, 2022 and June 11, 2022 it was documented that FC #4 eloped from the facility 12 times; Police Officers responded to calls from facility staff 13 times for "Missing person at risk, Involuntary Commitment, Urgent Welfare Check and Crisis; FC #4 went to the hospital three times for an Involuntary Commitment due to psychiatric concerns." Interview on 7/12/22 with a Police Officer revealed: -He thought he responded to 2-3 calls from facility staff about FC #4 walking away. The Officers he supervised responded other times. The other Officers responded several times, he wasn't sure how many. The times he responded FC #4 was walking down a road not too far from the facility. He thought the other Officers found him walking along that same road or other roads near the facility. He wasn't sure if the other Officers found him at an actual location. FC #4 told him he was going to the store and "rambling about something." He could not always understand what FC #4 was saying. He and the other Officers were concerned about FC #4's safety because he was walking down the road in the dark. Officers were looking for FC #4 early mornings and it was dark outside. FC #4 was leaving the facility around 1:00 am or a little later. They "Police Officers" were concerned FC #4 was going to get hit by a car. "[FC #4] should not be out walking alone because he had a Traumatic Brain Injury and didn't appear to be in control of all of his faculties." -He thought he went to the facility once because staff called and said they could not get FC #4 back into the facility. Officers also responded once out in the community, staff called and said they were following FC #4 in their vehicle. Staff were trying to get FC #4 into the vehicle and	V 111		

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V 111	Continued From page 6 return him to the facility. He thought those two incidents were put in as welfare checks. Interview on 7/11/22 with staff #1 revealed: -She was the House Manager for the facility and normally worked 1st shift. -FC #4 walked away from the facility several times. FC #4 mainly left the facility during third shift. FC #4 also left during 1st shift, she thought he left 3-4 times. FC #4 would tell them he was leaving and walk out the front door. FC #4 would say he was going to find a job, look for a car and a place to stay or he no longer wanted to be at the facility. During 1st shift it was normally more than one staff. If FC #4 walked away during 1st shift, staff would load the other clients into the van and search for FC #4. FC #4 would normally leave the facility and walk down one of the roads in this area. They did find him a few times when he was walking down the road. They called the police department each time FC #4 left the facility. "They wanted [FC #4] to be safe and were concerned because he had a Traumatic Brain Injury." -She confirmed FC #4 had no strategies to address his elopement from the facility. Interview on 7/11/22 with staff #2 revealed: -She worked 3rd shift at the facility. -She thought FC #4 left the facility 15 to 20 times between May and June 2022. -Her shift started at 9:00 pm, FC #4 was not always in bed when she arrived. FC #4 would normally be in the kitchen area. -FC #4 was "very loud, screaming and could be disruptive" prior to leaving the facility. Sometimes he "seemed to be in a manic state" prior to leaving the facility. She tried to redirect him numerous times and he would still leave the facility.	V 111		

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V 111	Continued From page 7 -Sometimes FC #4 would say he was leaving, other times he would just walk out the front door. FC #4 always walked out the front door, FC #4 actually pushed her twice because she stood near the front door trying to prevent him from leaving. FC #4 always left the facility after midnight. She could not follow him because she was working alone. "It was not fair to wake up the other clients and go search for [FC #4]." -Some nights FC #4 walked away from the facility multiple times, 2-3 times a night. She always called 911 to report that FC #4 walked away. She also contacted staff #1 and the Program Director each time FC #4 walked away from the facility. -The Police Officers would normally bring him back to the facility. They would normally find him walking down one of the main roads near the facility. The Police Officers would normally return him to the facility within an hour. FC #4 was away from the facility once for about 6 hours. She thought FC #4 went to the hospital about 3 times for psychiatric reasons after a police officer responded to him walking away from the facility. -She confirmed FC #4 had no strategies to address his elopement from the facility. Interview on 7/11/22 with staff #3 revealed: -She worked 1st shift at the facility. -FC #4 walked away from the facility a few times during 1st shift. She thought FC #4 left the facility 2-3 times. FC #4 would tell them he was going out to get a job and get a house. FC #4 would "cuss them out" if they tried to stop him from leaving. They called the police each time FC #4 left the facility. FC #4 would normally walk along the road adjacent to the facility and other roads in the area. She followed FC #4 in the van whenever he walked away. She tried to convince FC #4 to get back into the van and he often refused. She would follow FC #4 until the police	V 111		

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V 111	Continued From page 8 arrived. -She always called management when FC #4 left the facility. The Program Director could sometimes convince FC #4 to get in the van before the police arrived. -She thought FC #4 went to the hospital once when he walked away because he was "combative" when the Police Officers arrived. -She confirmed FC #4 had no strategies to address his elopement from the facility. Interviews on 7/7/22, 7/11/22 and 7/12/22 with the Program Director revealed: -FC #4 left the facilty several times. She was aware FC #4 had a history of elopement prior to being admitted to the facility. -Facility staff called the police department several times due to FC #4 eloping from the facility. She thought FC #4 left the facility at least 10 times or more. "It seemed like he was leaving the facility every other day." Staff didn't call the police department every time FC #4 left the facility, she thought the police department was called 6 or more times. FC #4 left more frequently during 3rd shift. She thought FC #4 left during first shift 2-3 times. Sometimes FC #4 would leave the facility 2-3 times in one day. FC #4 would push past staff and leave the facility. FC #4 would just walk out the front door. FC #4 was leaving the facility at 1:00 am or 2:00 am in the morning during 3rd shift. Staff had to call the police department. If it was early morning or late night staff should call the police department because they were normally working alone. During the day staff would go look for FC #4 because there are more staff available. -FC #4 would normally walk along the major highway near the facility. The Police Officers never really said where FC #4 was found when they returned him to the facility. She found FC #4	V 111		

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V 111	Continued From page 9 at a church about a mile from the facility in June 2022. She thought the police returned him to the facility because FC #4 was being combative. She also found FC #4 on June 11, 2022 at a local grocery store. FC #4 walked about 6 miles from the facility. She thought he left the facility around 1:00 am. Staff called the police department, however the the Police Officers said they were not able to find FC #4. A Silver Alert was issued for FC #4 and later cancelled because she found him at the grocery store. FC #4 left the facility again on June 11, 2022 in the evening. This time the police decided he needed to go to the hospital due to psychiatric reasons. FC #4 went to the hospital and never returned to the facility. -FC #4 came to the facility with an Individualized Support Plan (ISP) from the local LME/MCO. There were no strategies to address FC #4 eloping from the facility. She reached out to FC #4's Care Coordinator from the LME/MCO to see if the ISP could be revised. She also talked with the Care Coordinator about a Behavioral Support Plan (BSP) being created for FC #4. She was told she had to make the referral for the BSP to be developed. FC #4's Care Coordinator was aware he was leaving the facility at all times of the day. The LME/MCO Care Coordinator was responsible for the long term goals and the facility was responsible for the short term goals. "The long and short term goal must collaborate." She could not update FC #4's ISP without the Care Coordinator making their changes to the plan. FC #4's Care Coordinator never updated his ISP. -She confirmed FC #4 had no strategies to address his elopement from the facility. Review on 7/12/22 of a Plan of Protection (POP) written by the Program Director dated 7/12/22 revealed: "What immediate action will the facility take to	V 111		

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V 111	Continued From page 10 ensure the safety of the consumers in your care? 1 a. Moving forward LSC (Lutheran Services Carolinas) will ensure that additional staff is on shift to assist with client eloping. 1 b. LSC (Lutheran Services Carolinas) will consult with a psychologist/psychiatrist to create an elopement precausion plan for clients. Describe your plans to make sure the above happens. 2 a. [Program Director] will ensure that LSC (Lutheran Services Carolinas) and the MCO (Managed Care Organization) are in agreement with the proposed plan. 2 b. [Program Director] will ensure that all staff are properly trained on the clients plan including but not limited to elopement precausion. 2 c. [Program Director] will ensure that all proposed plan including supporting materials, equipment, documents are in place before the client moves into the facility." FC #4's diagnoses included Major Neurocognitive Disorder due to Traumatic Brain Injury with Behavioral Disturbance, Dementia, Moderate Intellectual or Developmental Disability, Seizure Disorder and Chronic Obstructive Pulmonary Disease. FC #4 eloped from the facility 12 times between May 18, 2022 and June 11, 2022. FC #4 was primarily leaving the facility during 3rd shift after 12:00 am when staff was working alone. Staff contacted the police department each time FC #4 left the facility. FC #4 was normally found walking along one of the roads near the facility. The Program Director found FC #4 at a church about 1 mile from the facility. FC #4 was also found by the Program Director at a local grocery store about 6 miles from the facility. The Police Officers were concerned for FC #4's safety because he was walking along the roadway in the dark and	V 111		

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V 111	Continued From page 11 could possibly be hit by a car. They were also concerned due to FC #4's mental capacity. FC #4 went to the hospital at least three times when Police Officers responded out in the community due to psychiatric concerns. FC #4 had a history of elopement, however he had no strategies to address his elopement from the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 111		
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 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;	V 367		

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MORETZ MANOR	409 EBON ROAD DURHAM, NC 27713

(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 12 (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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-621	A. BUILDING: _____ B. WING _____	R-C 07/12/2022

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V 367	Continued From page 13 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 record review and interview, the facility failed to ensure incidents were reported to the LME for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 7/7/22 of FC #4's record revealed: -Admission date of 5/18/22. -Diagnoses of Major Neurocognitive Disorder due to Traumatic Brain Injury with Behavioral Disturbance, Dementia, Moderate Intellectual or Developmental Disability, Constipation,	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 14 Dyslipidemia, Seizure Disorder, Chronic Obstructive Pulmonary Disease, Vitamin D deficiency and Polydipsia. -Discharge date of 6/11/22. Review on 7/11/22 of facility records for FC #4 revealed: Local Police Department Calls for Service: -5/25/22-Call for Service at 2:16 am-"Missing Person at Risk" -5/25/22-Call for Service at 6:10 am-"Missing Person at Risk" -There was no documentation of an incident report in the Incident Response Improvement System (IRIS) for the above allegation of abuse. Interview on 7/12/22 with the Program Director revealed: -Staff were supposed to document the incident in the web based program the facility uses for incident reporting. As the Program Director she was responsible for putting the incident into IRIS. She didn't think staff #2 made her aware of the incidents with FC #4 walking away from the facility twice on 5/25/22. -She confirmed the facility failed to ensure a Level II incident report was submitted to the Local Management Entity (LME) within 72 hours as required. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		

What is immediate action will the Facility take to ensure the safety of the consumers in your Care?

Moving forward Lutheran Services Carolina (LSC) will ensure that additional staff is on shift to assist with client eloping. LSC will consult with a psychologist or psychiatrist to evaluate an elopement precaution plan for the clients.

Describe your plan to make sure the above happens.

Program Director will ensure that LSC and the MCO agree with the proposed plan. Program director will also staff are properly trained on the client's plan including but not limited to Elopement precaution and procedure that are in company policy 2.18 Consumer Elopement and 2.44 Elopement Procedure.

2.18 Consumer elopement:

A. Prevention

1. Prevention of consumer elopement is a part of every staff n1etnber's responsibility. Prevention of elopement happens where there is appropriate accountability for consumers, when there is knowledge of consumer's tendencies, when there is appropriate suppo1is provided to consumers and when there is thorough and active communication among staff and consumers.

2. Any history of elope1nent should be documented in the individual's supervision plan (DDSN Directive 510-01-DD: Supervision of People Receiving Services).

3. The time immediately after an individual is known to have eloped is the n1ost impo1iant time in locating the individual pro1nptly and safely. Consequently, each Executive Director/CEO/Facility Administrator (ED/CEO/FA) is responsible to develop a thorough Consumer Elopement Policy.

a. Service Provider/Facility policy should contain a provision for regular co1nmunication with local law enforce1nent and rescue agencies about potential support needs to 1naintain readiness to assist in the event of a consu1ner elopement.

b. Service Provider/Facility policy should include a risk 1nanagen1ent provision for regular review of the adequacy of current supervision/precautions for consun1ers who have previously eloped.

c. Service Provider/Facility policy should include a provision to develop a brief profile of consumers with a known history of elope1nent to include photo, aliases, and areas consumer is known to frequent which can quickly be utilized to assist in the search for a consumer in the event of elopement.

B. Consumer Elopement

1. When it has been concluded that a consumer has eloped fro1n a Service

Provider/Facility, the ED/CEO/FA or designee shall take the following actions:

a. Notify the parent and/or guardian as soon as possible, but no later than one (1) hour after consumer is determined to have eloped. Provide updates on change in status of missing consun1er to parent and/or guardian as soon as possible. Communication with parent who is not guardian should only occur if the consumer has previously given pern1ission for such co1nmunication.

b. Asse1nble staff to initiate search for consumer as soon as possible.

1. A sufficient number of personnel should be involved in the search to facilitate rapid location of the consumer without jeopardizing the support provided to the other consumers.

ii. Staff should be assigned specific geographic areas to search to assure thorough coverage without duplication of effort.

c. No later than one (1) hour after the consumer is determined to have eloped, notification should be given to law enforcement agencies (City and County, those from the individual's hometown and/or in any other locale where evidence exists to suggest that locale as a possible destination).

1. Earlier notification of these law enforcement contacts should be carried out where the consumer poses a significant threat to self or others.

11. The ED/CEO/FA should also notify the District Director of all missing persons within one (1) hour after consumer has eloped (reference DDSN Staff Directory for weekend/night time contact telephone numbers).

d. Notify the local office of the Department of Social Services in the event the consumer is in the custody of that agency.

e. Notify the Department of Health and Environmental Control (DHEC), Division of Health Licensing via the DHEC online reporting system (http://www.scdhec.gov/Apps/Health/AIReports/DefaultAIPublic.aspx) of any consumer elopement from a Community Residential Care Facility (CRCF). Also immediately report consumer eloping from CRCF to local law enforcement and responsible party via telephone.

f. Notify DDSN of each consumer elopement via written Critical Incident

Report (see DDSN Directive 100-09-DD: Critical Incident Report).

g. If a consumer remains absent for more than 24 hours beyond initial determination of elopement, the ED/CEO/FA should consult with local law enforcement officials to determine if

the assistance of local media to broadcast missing consumer information to the general public is advisable.

1. Media contact should be initiated by local law enforcement officials as they are in charge of the search for the missing consumer.

11. The Associate State Director-Operations should be advised prior to any media contact

2.44 Elopement Procedure

Elopement Prevention:

Service Provider/Facility Policy should include a provision to develop a brief profile of consumers with a known history of elopement to include photo, aliases and areas consumer is known to frequent which can quickly be utilized to assist in the search for a consumer in the even of elopement.

These brief profiles are located in a folder in the house, as well as a folder in the van.

When it has been concluded that a consumer has eloped from a Service Provider/Facility (Lutheran Services of the Carolinas), the ED/CEO/FA or designee shall take the following actions:

1. Notify the parent and/or guardian as soon as possible, but **NO LATER** than one **(1) hour** after consumer is determined to have eloped. Provided updates on change in status of missing consumer to parent and/or guardian as soon as possible. Communication with the parent who is not guardian should only occur if the consumer has previously given permission for such communication.
2. Assemble staff to initiate search for consumer as soon as possible.
    a. A sufficient number of personnel should be involved in the search to facilitate rapid location of the consumer without jeopardizing the support provided to the other consumers.
    b. Staff should be assigned specific geographic areas to search to assure thorough coverage without duplication of effort.
3. No later than **(1) hour** after the consumer is determined to have eloped, notification should be given to law enforcement agencies (City and County, those from the person's hometown and/or in any other locale where evidence exists to suggest this as a possible destination.
    a. Earlier notification of these law enforcement contacts should be carried out where the consumer poses a significant threat to self or others.
    b. The ED/CEO/FA should also notify the District Director of all missing persons within (1) one hour after consumer has eloped. Reference DDSN Staff Directory for weekend/night time contact telephone numbers.
4. Notify the local office of the Department of Social Services in the event the consumer is in custody of that agency.

5. Notify the Department of Health and Environmental Control/Division of Health Licensing in writing of any consumer elopement from a community Residential Care Facility (CRCF) within **(10) days** of incident.
6. Notify DDSN of each consumer elopement via written Critical Incident Report.
7. If a consumer remains absent for more than 24 hours beyond the initial determination of elopement, the ED/CEO/FA should consult with local law enforcement officials to determine if the assistance of local media to broadcast missing consumer information to the general public advisable.
    a. Media contact should be initiated by local law enforcement officials as they are in charge of the search for the missing consumer.
    b. The Associate State Director-Operations should be advised prior to any media contact.
8. If a consumer remains absent for more than **72 hours** beyond initial determination of elopement, the ED/CEO/FA should consult with local law enforcement officials to determine if the assistance of "Crime Stoppers" to offer a reward for information leading to the location of the consumer is advisable.

Program Director will ensure that all proposed plans including supporting materials, equipment, documents are in place before the clients move into the facility.

Lutheran Service Carolina

Staff Development Training Roster

Inservice Training Title: Consumer Elopement policy

Training Location: Moretz Manor

Training Instructor: [redacted]

My signature verifies attendance and with any question being satisfactorily answered, full understanding of the information presented.

Name: Last First MI	Job Title	Shift	Date Completed
[redacted]	PD	1st	7/29/22
	DC	1st	7/29/22
	DC	1st	7/29/22
	DC	1st	7/29/22
	PM	1st	7.29.22
	DC	3rd	7/29/22
	DC	3rd	7/29/22

INSERVICE/TRAINING SIGNATURE SHEET

TITLE OF TRAINING: Incident Reporting & IRIS Reporting

DATE: 7.29.2022 LOCATION: Moretz DURATION: 90 min

SIGNATURE OF FACILITATO [redacted]

PRINTED NAME AND TITLE OF FACILITATOR [redacted] Program Director

BRIEF DESCRIPTION OF TRAINING: Incident Reporting, When and how to complete an IRIS Report

Participant's Signature	Printed Name	Title	Service Site
[redacted]	[redacted]	DC	Moretz
		DC	"
		DC	"
		DC	"
		BA	"
		PM	"
		DC	

INSERVICE/TRAINING SIGNATURE SHEET

TITLE OF TRAINING: Elopement

DATE: 7-29-22 LOCATION: [redacted] URATION: 1hr

SIGNATURE OF FACILITATOR: [redacted]

PRINTED NAME AND TITLE OF FACILITATOR: [redacted]

BRIEF DESCRIPTION OF TRAINING: Policy for Elopement. How to report incident and IRIS.

Participant's Signature		Title	Service Site
[redacted]		DC	Moretz Manor
		DC	Moretz Manor
		DC	Moretz Manor
		BA	Moretz Manor
		TD	Moretz
		PM	Moretz
		DC	Moretz

INSERVICE/TRAINING SIGNATURE SHEET

TITLE OF TRAINING: Plan of Correction & Clients Care

DATE: 7/13/22 LOCATION: Moretz DURATION: 90 min

SIGNATURE OF FACILITATOR: [redacted]

PRINTED NAME AND TITLE OF FACILITATOR: [redacted]

BRIEF DESCRIPTION OF TRAINING: Assessment Treatment Habilitation Service Plans, Incident Reporting and documentation, Chain of command

Participant's Signature		Title	Service/Site
[redacted]		DC	Moretz
		DC	Moretz
		DC	Moretz
		SA	LSC
		DC	Moretz
		DC	Moretz
		PM	Moretz

INSERVICE/TRAINING SIGNATURE SHEET

TITLE OF TRAINING: Client's Care

DATE: 5-26-2022 LOCATION: Moreta Manor DURATION: 1 hour

SIGNATURE OF FACILITATO[redacted]

PRINTED NAME AND TITLE O[redacted]

BRIEF DESCRIPTION OF TRAINING: Care in John Callahan and other Client and Clopenet.

Participant's Si[redacted]		Title	Service Site
		LC	Moreta Manor
		DC	
		DC	Moreta Manor

INSERVICE/TRAINING SIGNATURE SHEET

TITLE OF TRAINING: Documentation / Incident Reporting

DATE: 4/15/2022 LOCATION:

SIGNATURE OF FACILITATOR: [redacted]

PRINTED NAME AND TITLE: [redacted]

BRIEF DESCRIPTION OF TRAINING: [redacted] Progress Notes + Behavior Data

Participant's Signature	Title	Service Site
[redacted]	DC	Moretz Manor
	DSP	Moretz Manor
	DC	Moretz Manor
	DC	Moretz Manor
	DC	Moretz Manor
	DC	Moretz Manor
	PM	Moretz Manor
		Moretz Manor