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V 000	INITIAL COMMENTS An annual and follow up survey was completed on March 3, 2023. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600D Supervised Living for Minors with Substance Abuse Dependency. This facility is licensed for 10 and currently has a census 4. The survey sample consisted of audits of 3 current clients, 4 former clients and 1 deceased client.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement strategies based on the assessment for one of one deceased client (DC) (#1). The findings are:

Review on 03/01/23 and 03/02/23 of DC #1's record revealed:
- 17 year old female.
- Admission date of 11/13/22.
- Diagnoses of Opioid Use Disorder, Cannabis Use Disorder, Unspecified Depressive Disorder, Oppositional Defiant Disorder and Post Traumatic Stress Disorder.
- Elopement from the facility on 12/06/22.
- Found deceased on 12/18/22 in home county approximately 178 miles from the facility.

Review on 03/02/23 of DC #1's Person-Centered Profile (PCP) "Comprehensive Crisis Prevention and Intervention Plan" dated 10/13/22 and amended on 11/03/22 revealed:
- "What are the early signs that I am not doing well? What will others notice about my behavior, speech, and actions when I am not doing well? Describe what others observe when s/he is entering a crisis episode...'I would be screaming and walking away telling people to leave me alone.' Amended 11/3/22: If triggered, patient indicated that staff would observe the following:

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being sneaky, quiet, or I would just leave and not care. Patient indicated that staff will be able to tell when angry as patient would try to show I am not angry. I will laugh then I get quiet before I will start saying what I really want to say. Patient indicated that staff will be able to tell when triggered as patient would start looking for a way out of lies to someone who is not a fan of me using. Patient indicated that staff will be able to tell when flirting or engaging in promiscuity as patient would giggle a lot, give them lots of attention, try to help take care of them, and talk to them a lot. Amended 11/28/22: I get super defensive, mean and I will want to hurt something or destroy something."
- "How can others help me and what can I do to help myself to address a crisis early on? Who is best able to assist me? Describe prevention and intervention strategies that have been effective in reducing stress, problem solving, in keeping the person from needing higher levels of care such as a trip to an emergency room or crisis center or inpatient hospitalization ...Amended 11/3/22: if the patient were to verbally express a desire to elope from the facility the following would occur: patient would be placed on a 1:1 with staff and patient's name would be changed on the bead board to red so that all incoming staff would be aware of the patient's high risk status. If the patient chooses to elope from the facility, staff would follow our running away protocol. Staff would initially search the campus and attempt to locate the patient. If patient cannot be found or is refusing to return to the program, program supervisor, LRP (Legally Responsible Person), and probation would be notified in order to determine if law enforcement intervention is necessary. If patient were to report experiencing these triggers or if staff observes patient to be escalating, then staff would remove patient from

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the current setting if able and mindset would be utilized to deescalate the patient. The patient's name would be changed on the bead board to red so that all incoming staff would be aware of the patient's high risk status. If patient is unwilling or unable to deescalate then program supervisor, LRP, psychiatrist (if applicable) and probation (if applicable) would be notified in order to determine if an IVC (Involuntary Commitment) or law enforcement intervention is necessary..."

Review on 03/03/23 of an individual group therapy note note for DC #1 dated 12/06/22 and signed by Associate Professional (AP) #2 revealed:
- "Start of the shift patient (DC #1) participated in art group, patient worked on painting an ornament for the tree. Patient was focused and completed her project with no issues. Patient cleaned her area then returned to the day room where she watched the news and talked with peer. Patient made her call to her sister and spoke about not being here anymore. Patient stated she can't do the program and either way she would be locked up any way. Patient told her sister she does not know how much longer she will be at PORT. Patient later return to her room where she took her shower, patient returned to the day room where she watched the news while waiting for dinner. Patient washed up for dinner, patient recited the serenity prayer then ate her dinner following all expectations as well as having conversations with peer. Patient cleared her area and returned to the day room and watched the news until quiet time, while in the day room patient continued being sneaky whispering to peer then asked staff if bears are out tonight. Patient struggles tonight with following directions and being positive. Patient went to her room for quiet time. Patient was monitored while in her

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room during quite time due to reports of patient running. Patient returned to the day room for pm group. Patient struggled to stay positive and focused. Patient started being rude and disrespectful to her peer making attempts to cause chaos during group. Patient was given several redirections on behaviors however refused to be respectful and focused on group. After patient got no response from peers patient left group and went to her room. Patient was in her room about 5 minutes then later walked out the side door. At 8:35pm patient eloped the facility, staff left to look for patient at 8:38. At 8:40 supervisor [Clinical Services Manager] was notified of the incident. At 8:45 the patients court counselor called Port due to patients monitor being cut off her ankle, court counselor was notified of patient's elopement from the facility. At 8:50pm staff contacted [Local] Sheriff Office of the incident. At 9:20 deputy showed up to speak with staff. 9:30 court counselor called to let staff know there is an order for secure custody. Court Counselor faxed the order to the [Local] Sheriff office. At 9:40 staff returned to the facility with no luck finding patient. At 10pm staff returned to make a second attempt to locate patient."

Review on 03/01/23 of a North Carolina Incident Response Improvement System (IRIS) report originally submitted on 12/08/22 and last submitted on 12/21/22 for DC #1 revealed:
- Provider Comments: "(12/08/22) Patient (DC #1) exited the building out the side door of the dormitory. Patient did not speak with staff before elopement. Patient was on electronic monitoring, but removed her ankle bracelet prior to elopement from the facility. (12/08/22) When patient left, a staff member (#3), per procedure, drove around looking for the patient. Staff member was unable to locate the patient.

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V 112	Continued From page 5 Authorities were contacted. Patient remains missing at this time. The patient's probation officer has issued a secure custody order once the patient is located. (12/14/22) [Local] County Sheriff Facebook Page/Crime Stoppers post made on 12/13/2022 identifying patient as a missing juvenile and requesting assistance locating her. (12/20/22) Spoke with [Probation Officer], patient's probation officer in [Home County] County. Ms. [Probation Officer] reports that patient's body was located in [Town in Home County] on Sunday (12/18/22). Patient's body is being sent for an autopsy, but from what Ms. [Probation Officer] understands, patient is suspected to have overdosed. Autopsy and toxicology report has been requested and will be uploaded once received." - "Describe the cause of this incident, (the details of what led to this incident). A review of the incident, including staff and patient interviews, revealed the teen had a plan to leave treatment to use substances." - "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. For this particular patient, since she was admitted on electronic monitoring in an attempt to minimize elopement risks. On three separate occasions, this teen removed herself from the group; however, did not run away and returned to the group and verbalized that she was mindful of her ankle monitor. Additionally, the program model is structured to address substance use and subsequent cravings, including giving patients access to staff and peer support to manage thoughts of relapse. Patients also have access to multiple coping interventions to prevent incidents."	V 112		

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V 112	Continued From page 6 Review on 03/01/23 of a North Carolina IRIS report originally submitted on 12/21/22 and last submitted on 01/05/23 for DC #1 revealed: - Death Information Unknown Cause. - Provider Comments: "(12/21/22) On 12/19/2022, provider was contacted by consumer's (DC #1's) sister who reported that consumer was located on 12/18/2022 deceased. Consumer's sister indicated that consumer likely overdosed, however autopsy will be conducted. On 12/20/2022, program supervisor contacted consumer's probation officer to confirm report. Probation confirmed consumer death. Autopsy pending suspected overdose. Police report, autopsy and toxicology reports were requested at that time. (12/22/22) [Town in Home County] Police Lead Detective on the case is out on vacation until next Tuesday 12/27/2022. Per dispatch, the file is in "red" which means that they are unable to access the report without the lead detective's consent or permission. Dispatcher advised to call back on Tuesday and speak with Detective [Detective Name]. (12/27/22) Program supervisor contacted [Town in Home County] Police Department as advised from last week. Program supervisor requested to speak with Detective [Detective name]. Dispatch transferred program supervisor to Detective [Detective Name]'s direct line, but received voicemail. Voicemail left requesting return call as soon as possible. Will continue to update as more information is available. (01/05/23) Program supervisor has continued to reach out to Detective [Detective name] with [Town in Home County] Police Department for a police report or update on patient's case in order to document in patient's chart and IRIS, but has not had any success. [Local] County CrimeStoppers in collaboration with [Local] County Sheriff's Office posted a photo on yesterday, 1/4/2023, with	V 112		

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patient's photo updating their followers on patient's death. The post reported that patient was found in a motel room alone, deceased, and the cause of death was likely an overdose on multiple substances. The post continued on to discuss why CrimeStoppers posts this information, as well as why it posts information of missing juveniles in an attempt to locate them safely. Program supervisor, as mentioned in previous report, has requested autopsy and toxicology reports from the NC (North Carolina) Medical Examiner and is still awaiting those results."
- "Describe the cause of this incident, (the details of what led to this incident). It is difficult to determine a cause of the incident, given the cause of death has yet to be determined."
- "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Consumer last received services on 12/6/2022. It is hard to determine corrective measures as the cause of death has yet to be determined and consumer chose not to engage in treatment."

Review on 03/02/23 of "Timeline of Events [DC #1]'s Elopement 12/6/2022" revealed:
- "Shift Change at 4:00pm
- Art Group-Patient (DC #1) painted an ornament for the dorm Christmas tree and did not exhibit any behavioral issues, nor did she verbalize or endorse any complaints.
- Patient made a phone call to her sister and spoke about not being able to be here anymore.
- Patient stated that she cannot do the program and either way, she would be 'locked up anyway.'
- Patient told her sister that she did not know how much longer she would be here at PORT.

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V 112	Continued From page 8 - Patient ate dinner with her peers without complaints. - Patient participated in quiet time, but displayed sneaky behavior as evidenced by whispering with a peer and asking if there were bears out tonight. Staff also reported that patient struggled with following directions and being a positive influence to the group. - PM Group-Patient struggled to stay positive and focused on the group. Patient started being rude and disrespectful towards a peer, making attempts to cause chaos during group. Patient was redirected multiple times, but patient was non-complaint with redirections. Patient decided to leave group and go to her room when the peers would not respond to her behavior. - Patient was in her room approximately 5 minutes before walking out the side door of the facility. - Approximate time of elopement: 8:35pm - Staff departed in search of patient at 8:38pm. - Manager [Clinical Services Manager] notified of patient elopement at 8:40pm. - Patient's court counselor, [Probation Officer], called PORT and notified staff that patient's electronic ankle monitor had been cut and removed. [Probation Officer] was also notified that patient had eloped from the facility at this time. Notification at approximately 8:45pm. - [Local] County Sheriff's Office contacted at 8:50pm to notify of patient elopement. - Program Supervisor [Program Supervisor] notified of patient elopement at 9:00pm..." Review on 03/03/23 of the client "Orientation Handbook" revealed: - "Running Away In the event your teen runs away from the program, the following procedure will be followed in addition and accordance with the crisis plan: 1. The staff will utilize the crisis plan	V 112		

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for guidance on how to respond. The crisis plan will determine the course of action in addition to the following procedure. 2. The staff will attempt to locate your teen including searching the grounds/campus or immediate area where your teen was last seen..."

Review on 03/03/23 of the facility policy and procedure for elopements revealed:
- "Runaway Procedure: Upon admission into the program, the person served signs a statement reading that they will not run away and will successfully complete the prescribed program. The program recognizes the reality that running away and escaping are often used in the denial process of a substance abuser; therefore, if a person served does run away, it certainly does not mean actions for dismissal would be taken. Instead, a proper therapeutic procedure will be followed. Procedure: If a person served shares that he/she is considering running away, then the staff will be notified and the client will be supervised including but not limited to the client sleeping on the couch rather than his/her room and the client not being allowed to go to their room unsupervised..."

Interview on 03/02/23 staff #1 stated:
- She had worked at the facility for approximately 1 year.
- She did not recall specifics of DC #1's elopement or behaviors before DC #1 left the facility.
- If clients want to leave their peers will tell staff.
- There are always at least 2 staff at the facility.
- If a client was suspected of possibly running the staff "keep an eye" on them.

Interview on 03/02/23 staff #3 stated:
- He was on shift the night DC #1 eloped.

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- He did not recall all the specifics of DC #1's elopement and did not know if she was on 1:1.
- He was the staff who looked for DC #1.
- If clients self harm or harm a peer they may be on 1:1 which would be sitting at the bedroom door.
- Staff always follow the crisis plans for elopements.

Interview on 03/03/23 AP #1 stated:
- She started working at the facility July 2022.
- She normally worked 2nd shift 4pm to 12 midnight and on weekends.
- She recalled when DC #1 eloped from the facility on 12/06/22. She, staff #1 and staff #3 were at the facility.
- She had written the 12/06/22 note for DC #1.
- Staff monitor the phone calls. Staff had apparently overheard DC #1 stating she wanted to leave. They write the information on a log book and then it is written as a note.
- Staff deescalate if a client is attempting to elope.
- A group meeting was held at 8pm for the clients.
- DC #1 had tried to get a reaction after about 30 minutes of group.
- DC #1 had then walked to her room.
- She went to DC #1's bedroom and knocked on the door. DC #1 indicated she was in the bathroom and she went to sit at the staff desk at the entrance of the residential hallway.
- DC #1 was in her room about 5 minutes or less and "I saw her walking out the door and said don't do it."
- Staff began calling the guardian and court counselor after DC #1 left.
- DC #1's Probation Officer called and said DC #1 had taken off her ankle monitor.
- Staff went out in the community looking for DC #1 and law enforcement was notified.
- After an incident at the facility staff come

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together to review the issues.
- She was not sure who determined 1:1 for the clients if needed.
- She felt the staff had supervised DC #1 well.
- She did not recall anyone being on 1:1 staffing.

Interview on 03/01/23 and 03/03/23 the Program Supervisor stated:
- She began working at the facility on 11/14/22.
- Client's crisis plans are followed during elopements.
- Staff monitor all the phone calls of the clients.
- She understood DC #1's PCP Crisis Plan indicated 1:1 staff if DC #1 expressed a desire to elope.
- She created the timeline of DC #1's 12/06/22 elopement based on interviews and documents.
- She only recalled one episode of 1:1 staffing at the facility.

Interview on 03/03/23 the Clinical Services Manager stated:
- She or the Program Supervisor would determine 1:1 staff.
- Staff would contact them and then the decision would be made for 1:1.
- Everyone was upset with the situation with DC #1.
- She felt staff provided support to DC #1 at the facility.
- She watched the video and felt staff supervised DC #1 well.
- The video did not record inside DC #1's room.
- The video showed what the staff had verbalized to surveyor.
- Staff was at the desk and was near DC #1's room. DC #1's room was the first room on the hallway and in close proximity to the staff desk.
- DC #1 went to her room to process.
- DC #1 came out of her room and walked out the

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door.
- Staff completed the elopement protocol.
- DC #1 had walked off before and staff were able to encourage her back to the facility.
- She was aware of DC #1's crisis plan.

Interview on 03/03/23 a representative from the North Carolina Office of Chief Medical Examiner stated DC #1's autopsy and toxicology results were pending and a report would be sent when complete.

Review on 03/03/23 of the facility "Plan of Protection" signed by the Clinical Services Manager and dated 03/03/23 revealed:
- "What immediate action will the facility take to ensure the safety of the consumers in your care? The immediate plan of protection will include the following: 1. Staff will review the crisis plan for all new admissions and current patients to ensure their understanding and familiarity with individualized interventions for crisis response. 2. Staff will sign off on the crisis plans for all new admissions. The staff currently sign off on the PCP and crisis plan as a combined document. To ensure the crisis plan is specifically reviewed staff wil 3. The program supervisor and program manager will provide supervision for the staff regarding the findings of the DHSR (Division of Health Service Regulation) survey on 3/3/23 and document staff having received this information specifically focusing on crisis plan implementation.
- Describe your plans to make sure the above happens. How to prevent in the future:
1. As stated above, the staff will be notified upon admission information regarding specific crisis plan response based on individual need. Staff will review and sign off on the crisis plan as an individual document. 2. All incidents will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL074-111	A. BUILDING: _____ B. WING _____	R 03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORT HEALTH SERVICES - GREENVILLE RESIDENTI	114 HEALTH DRIVE GREENVILLE, NC 27834

(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 reviewed with staff to process incident response in accordance with the crisis Supervision will be provided for all incidents and training on crisis plan implementation provided as needed." DC #1 was a 17 year old female. She had diagnoses of Opioid Use Disorder, Cannabis Use Disorder, Unspecified Depressive Disorder, Oppositional Defiant Disorder and Post Traumatic Stress Disorder. She had an ankle monitoring device and was monitored by a probation officer. On 12/06/22 staff documented DC #1 was having sneaky behaviors and indicated she did not want to be at the facility. DC #1 had a crisis plan and which outlined measures to be instituted for elopement precautions. During the 8pm group DC #1 was allowed to go to her room. DC #1 had removed her ankle monitor and eloped from the facility. The crisis plan indicated 1:1 staff should be implemented for the elopement precautions. The facility failed to implement the strategy identified in the crisis plan of assignment of a 1:1 staff for DC #1. DC #1 eloped from the facility and was found deceased on 12/18/22. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $10,000 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 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local	V 114		

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V 114	Continued From page 14 authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure fire and disaster drills were held at least quarterly and repeated on each shift. The findings are: Review on 03/01/23 of facility records for 2022 revealed: - No fire drills documented for the 12 hour weekend shift from 12am to 12pm and 12pm to 12am. - No disaster drills documented for the 12 hour weekend shift from 12am to 12pm a 12pm to 12am. Interview on 03/01/23 and 03/03/23 the Program Supervisor stated: - The facility completed fire and disaster drills monthly. - The facility had 3 shifts during the week and 2 shifts on the weekends. - 1st shift 8am to 4pm. - 2nd shift 4pm to 12 midnight. - 3rd shift 12 midnight to 8am. - Weekend Saturday and Sunday 12am to 12 pm. - Weekend Saturday and Sunday 12pm to 12am.	V 114		

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V 114	Continued From page 15 - She understood the weekend shifts were required to have fire and disaster drills completed monthly. Interview on 03/03/23 the Clinical Services Manager stated: - The same staff work during the week and on the weekend and particiapted in drills. - She understood the weekend shifts were required to have fire and disaster drills completed monthly.	V 114		