STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-666	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT HOME	2204 OAKMONT COURT GREENSBORO, NC 27407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on July 26, 2023. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability. This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105		

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V 105	Continued From page 1 (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to determine their ability to provide services to address the individual needs of 1 of 3 clients (#3). The findings are: Review on 7/26/23 of the facility's 12/15/22 admission policy and procedure revealed: -The licensee's professional staff, who included an assigned Qualified Professional (QP) and Program Director, were responsible for gathering and reviewing all evaluations, assessments and any additional information of an individual being considered for admission. -No information was specified as to who of the licensee's professional staff made the decision whether or not to accept an individual for admission. Review on 7/18/23 of Client #3's record revealed: -Admission date of 6/12/23. -Diagnoses of Autism and Oppositional Defiant Disorder (ODD). -15 years old. -A 6/8/23 screening/referral form completed by QP #3 included Client #3's issues of verbal aggression, "social concerns" (not specified), and defiance. -A 2/9/23 cover letter from the Department of Social Services (DSS) to "To Whom It May Concern" with the following attachments: -A history of multiple placements since 10/13/16. -Prior placements included family foster homes, therapeutic foster homes, 2 admissions to psychiatric residential treatment facilities (PRTFs), 2 psychiatric hospital admissions, and	V 105	Our intake Specialist will complete the assessment prior to service delivery. the assessment will include the following at a minimum: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis (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.	8-16-2023

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V 105	Continued From page 3 an admission from 5/12/23 to 6/12/23 at a crisis center. -A documented history of elopements. -An 8/23/22 treatment plan from most recent PRTF admission. -He was transferred from the PRTF for hospitalization on 9/19/22-12/17/22 and from 12/27/22-5/1123 and then moved to a facility crisis center on 5/12/23 until 6/12/23. -There was no documentation from the hospital or crisis facility regarding the level of care needed. Interviews on 7/18/23, 7/19/23, and 7/26/23 with QP #1 revealed: -This was Client #3's 13th placement. -"He has eloped at all other facilities." -He interviewed Client #3 during his admission screening on 6/8/23. -He had concerns about Client #3's elopement history and familiarity with the city and neighborhood where the facility was located. He communicated both these concerns to the Clinical Director, Clinical Manager/QP #2, and a former QP who he was shadowing. -The decision to admit Client #3 was a "joint decision" by the Clinical Director and Clinical Manager/QP #2, and the former QP who had "all the information" about Client #3's past placements, elopement history, and familiarity with the geographical area. -Since his admission, Client #3 had 5 separate elopement incidents- 6/17/23 to 7/3/23 (2 weeks), 7/8/23 to 7/10/23 (2 days), 7/16/23 to 7/17/23 (1 day), 7/19/23 (several hours), and 7/25/23 (unknown duration). -On 7/25/23, Client #3 "eloped from his bedroom window at 9:28 a.m. and his whereabouts were unknown."	V 105		

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V 105	Continued From page 4 -As of 7/26/23, Client #3 was being "immediately discharged." Interview on 7/20/23 with the Clinical Manager/QP #2 revealed: -Client admission screenings were conducted by a QP, then followed up with consultation from the Program Director (PD) to determine whether or not an individual would be a "good fit" for placement. -"We knew at screening he (Client #3) had elopement issues. Our (QP #1 and PD) biggest concern was he was familiar with [the city and facility location] and we questioned whether he was a good fit considering he knew the city and had a history of elopement." -Client #3 was an "emergency placement." -"We understood (from the referral source) this would be a temporary placement." Interviews on 7/24/23 and 7/26/23 with the Clinical Director revealed: -"That part (admission decision for Client #3) was on me." -"We got an emergency referral, and he (Client #3) was the only one who didn't work out (no changes in elopement and defiance behaviors)." -The clinical team (QP #1 and Clinical Manager/QP #2) explained Client #3's situation and "advised" him "we didn't think he (Client #3) would be a good fit because of his elopements, and he knew [the city]." -"It was a temporary placement. I said okay and go ahead (with the admission). It was against my better judgement." -There was no specified time frame for Client #3's "temporary" placement. -He had seen "positive" differences in other clients within a week of their admission and who had similar issues as Client #3.	V 105		

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V 105	Continued From page 5 This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 105		
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 referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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V 111	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to document strategies to address 1 of 3 clients' (#3) presenting problems prior to the delivery of services. The findings are: Reviews on 7/24/23 and 7/26/23 of Client #3's record revealed: -Admission date of 6/12/23. -Diagnoses of Autism and Oppositional Defiant Disorder (ODD). -15 years old. -A treatment plan dated 8/23/22 from a psychiatric residential treatment facility (PRTF) included strategies to address Client #3's issues of verbal aggression, social concerns, and defiance. A potential barrier to Client #3's discharge was a "lack of care for his own safety in an attempt to avoid following directives raises concerns." -There were no documented strategies prior to 7/11/23 that addressed his issue of elopement. Review on 7/18/23 of an internal facility incident report dated 6/17/23 for Client #3 revealed: -At 1:30 pm, Client #3 walked out of Staff #3's vision and eloped from the facility after he refused to follow the staff's instructions to change his bed linens, used profanity ("Leave me the f**k alone" and "f**k this s**t") toward staff, then stated "I'm gone." -He refused Staff #3's attempts to process with him what was wrong and return to the facility.	V 111 V 111	Prior to or within 30 days of admission an ISP will be developed based on assessment and with input from the client or guardian. It will include, Goals, strategies, staff responsible, expiration date and an indication of how the goal will be reached.	08-18-2023

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V 111	Continued From page 7 Review on 7/20/23 of staff notes dated 7/5/23 to 7/8/23 for Client #3 revealed: -When prompted by a staff (Program Director, #3, #4 and #6) to complete an activity, Client #3 responded with verbal aggression toward staff such as "I don't have to listen to you," "I don't have to go if I don't want to," and "f**k you." He then went into his bedroom and closed the door. -On 7/8/23 around 1:00 p.m., Client #3 eloped from his bedroom window after he "punched a hole in the wall", called Staff #6 "ignorant," refused Staff #6's prompts to clean his room and shower, and told Staff #6 to "get the f**k out of his room." He "gave the middle finger" when Staff #6 asked him to come back to the facility. Attempted interviews on 7/18/23, 7/19/23 and 7/24/23 with Client #3 revealed: -7/18/23, he was not present at the facility to be interviewed because he was at a camp. -7/19/23 and 7/24/23, he refused to answer any questions. Interview on 7/18/23 with Staff #1 revealed: -Client #3 was "very defiant. He has eloped 3 or 4 times since he's been here (facility). He just got here in June (2023)." -"I just talk to him (Client #3) and tell him to go to his room when he's upset." Interview on 7/18/23 with Staff #3 revealed: -Client #3 was "defiant about everything." -"He (Client #3) does not want to be told what to do." -The first time he eloped was over Juneteenth (6/17/23). " ...when asked to clean his room and he said no, (he) wanted his room junky ... (Client #3) asked (Staff #3) for a bag to clean his room and the next thing I heard the window alarm go	V 111		

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V 111	Continued From page 8 off. He was already outside and wouldn't come back." Interview on 7/24/23 with the Qualified Professional (QP#1) revealed: -Client #3's treatment plan dated 8/23/22 was used for "informational purposes" and as "guidelines." -"We followed parts of that plan to deal with his behaviors." Interview on 7/26/23 with the Clinical Director revealed: -Client #3's treatment plan (8/23/22) from his previous placement was "followed to a degree. It was used as a guide to his daily living skills." -At Client #3's admission, "all" the alarm sensors were working and there were 2 staff on all shifts to provide eyesight on Client #3 at the facility. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 111		
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	V 112		

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V 112	Continued From page 9 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		
	This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to implement treatment strategies to address the needs for 1 of 3 clients (#3). The findings are: Review on 7/18/23 of Client #3's record revealed: -Admission date of 6/12/23. -Diagnoses of Autism and Oppositional Defiant Disorder (ODD). -15 years old. -A history of elopements. Reviews on 7/19/23, 7/24/23 and 7/26/23 of Client #3's treatment plan dated 7/11/23 revealed: -"What's not working? [Client #3] has a history of being noncompliance, utilizing verbal aggression and elopement from programs ...Since being	V 112	Prior to or within 30 days of admission an ISP will be developed based on assessment and with input from the client or guardian. It will include, Goals, strategies, staff responsible, expiration date and an indication of how the goal will be reached.	08-18-2023

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V 112	Continued From page 10	V 112		

placed with [Licensee]; he has had multiple episodes of elopement. [Client #3] has been giving a 60 day (notice) at this time for discharge due to ongoing behavior challenges and safety risk. He needs ongoing 24 hrs (hours) supervision to ensure all needs are met and safety risk is reduced."
-"[Client #3] needs to be placed in a supportive environment per the right level of care that can adequately manage his challenging behaviors that reduce safety risks."
-"Oakmont is a temporary placement until the appropriate level of care placement has been identified and secured."
-Included a goal of "will stay within eyesight of staff when in the community and home setting."
-Staff strategies were to:
-"Provide him (Client #3) with ongoing 24 hours supervision."
-" ...use proper safety interventions AEB (as evidenced by) utilizing emergency services, crisis prevention tactics and proper reporting ...use interventions as documented in his crisis prevention and intervention planning."
-"Strategies for crisis response and stabilization ...Allow time for him (Client #3) to reflect and walk away from the situation that causing stressors; but keep in eyesight (24 hrs (hours) supervisor is imperative)."

Review on 7/24/23 of staff notes dated from 7/5/23 to 7/19/23 revealed:
-7/16/23, Client #3 refused to participate in a planned outing, hit the screen door, and threw a fan. "Using lots of profanity and called staff ugly and using curse words." At approximately 3:34 p.m., Client #3 was found gone from the facility when Staff #6 opened Client #3's locked bedroom door.
-7/19/23, Client #3 refused to follow Staff #3's

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prompt to clean his room before he left for camp. He then refused to be redirected by Staff #3 to move from the front seat of the facility van to the backseat before he broke the van's windshield.
-There was no documentation that Client #3 tried to self-harm during the 7/19/23 incident.
-There was no documentation of crisis prevention strategies such as utilizing emergency mobile crisis services when Client #3's verbal aggression escalated to property destruction.

Review on 7/24/23 of email correspondence between Client #3's treatment team from 6/19/23 through 7/19/23 revealed:
-The emails were communications between the facility's Qualified Professional (QP #1) and Client #3's treatment team (an LME/MCO (Local Management Entity/ Managed Care Organization) Care Coordinator, a LME/MCO Care Coordinator Supervisor, Client #3's Department of Social Services (DSS) guardian, a Guardian Ad Litem, and facility management (Program Director (PD), QP #1, Clinical Manager/QP#2, QP Supervisor and Clinical Director).
-An undated email (no time specified) from QP #1 to Client #3's team communicated that Client #3 continued to be defiant in areas of showering, eating his meals, and not cleaning his room. He had removed the alarm sensors from his window and made verbal threats to staff such as "I will kill you."
-An email dated 7/17/23 at 9:32 a.m. from QP #1 to Client #3's treatment team notified the team of Client #3's elopement from the facility on 7/16/23 around 4:00 p.m. A staff (Staff #6) was making staff rounds, unlocked Client #3's door, found the window sensors removed, and did not find Client #3 in his room.
-An email dated 7/19/23 at 1:02 p.m. from Client #3's DSS guardian to his treatment team

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revealed:
-Statements about Client #3's property destruction to the facility van, "he (Client #3) tried to harm himself, and the police were there (facility) multiple times."

Observations on 7/19/23 from 10:48 a.m. to 11:30 a.m. at the facility revealed:
-Client #3 walked into the facility accompanied by 2 local law enforcement officers and walked to his room. The officers spoke with Staff #1 and #3 in the living room and then left the facility.
-At 11:06 a.m., Client #3 walked unaccompanied (no staff) through the living room and into the hallway toward the front door. Staff #1 was cleaning the kitchen floor and the location of Staff #3 was unknown.
-A door was heard opening and Staff #1 was notified that "someone just went out the door." Staff #1 looked out the kitchen window and immediately called Staff #3's name. Staff #3 ran through the living room toward the front door. Both Staff #1 and #3 talked with Client #3 who was outside standing beside the facility van. At 11:10 a.m., Client #3 re-entered the facility and walked back toward his bedroom.

Attempted interviews on 7/18/23, 7/19/23 and 7/24/23 with Client #3 revealed:
-7/18/23 at 5:30 p.m., he was not present at the facility to be interviewed.
-7/19/23 and 7/24/23, he refused to answer interview questions.

Interviews on 7/18/23 and 7/24/23 with Staff #2 revealed:
-Client #3 "usually" eloped during the daytime and not at night.
-Client #3 started attending a camp on 7/18/23.
-"I don't have a problem with him when I work. He

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V 112	Continued From page 13 has said before that women should not be working in a group home with boys; they didn't know about boy stuff. Not sure what that means about boy stuff." -Client #3 removed the alarm sensors off his window "a couple of times and went out the window." -The window alarm sensors were "the detachable kind." -The alarm sensors were supposed to alert staff if Client #3 tried to open the window. -"He definitely needs more supervision. He needs eyesight on him when he goes outside. I understand he can't go out the door without eyes on him." -Client #3 was not supposed to lock his bedroom door. -If Client #3 ran from the facility again, "we (staff) can't do anything but call 9-1-1. If it's something (a crisis behavior) he does here (facility), we can call mobile crisis and a worker will come talk to him." Interview on 7/24/23 with Staff #3 revealed: -Client #3's supervision level was "basically 24-hour watch. That means we keep checking on him every few minutes. We keep him in eyesight when he's in the living room and other common area (dining room). When he is in his room, he wants the door shut and we let him do that for a few moments. Do 5-minute checks." -"At night, his checks are every 30 minutes." -"He's allowed to be in his room and lock the door. That's [the Licensee] policy." -"We have a No Chase policy if someone elopes ... we don't go after them (clients). If someone is in crisis, we call the mental health mobile crisis or law enforcement. We call law enforcement when [Client #3] runs because he's gone and has to be located."	V 112		

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V 112	Continued From page 14 -Client #3 removed the window sensors (7/16/23) but the sensors were back working on his window. -Since Client #3's elopement on 7/19/23, there was an additional staff placed in the facility for a total of 3 staff when Client #3 was present in the facility. -"If he goes to his room, staff are closer to the outside of his room to listen more intently and encourage him not to lock the door. We have pulled up a chair right outside his room." Interview on 7/24/23 with Staff #4 revealed: -He understood Client #3 had "lots of placements" prior to his admission and "was a high elopement risk; he ran from past placements to the point he needed 24-hour monitoring." -"I have not read his treatment plan for here (facility). I don't know that it has gotten to us (staff) yet." -QP #1 was trying to "look into what all services he needed." -Since Client #3's 7/19/23 elopement, there were 3 staff on duty at the facility during the day with the PD and QP #1 working as the 3rd staff. Interviews on 7/18/23, 7/19/23 and 7/24/23 with the PD revealed: -Client #3 was attending a camp (on 7/18/23) and not expected to return to the facility until 6:30 p.m. -She and Qualified Professional (QP #1) were leaving the facility (7/19/23 at 10:00 a.m.) to have Client #3 IVC 'd because he broke the van windshield and eloped from the facility. -She was concerned Staff #1 or #3 did not intervene to "immediately stop (Client #3) from walking out the door" after he was returned to the facility by law enforcement. She stated, "one of the 2 staff (Staff #3) should have been looking at	V 112		

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V 112	Continued From page 15	V 112		

the camera monitor (located in staff office)."
-Prior to Client #3's admission, there were sensors on his window and bedroom door, and a camera system in place.
-Client #3's supervision level was "when he's in his room, staff can use their discretion but (were to) check on him about every 5 minutes."
-The 5-minute staff checks "agitated" Client #3 which led to his using profanity and saying, "leave me the f-alone."
-"If he is agitated, we'll give him time to himself and go back maybe every 15-30 minutes and check on him."
-"When there was just female staff, he wants to stay in his room; he wants his privacy and that's their (clients') right."
-Since Client #3 returned to the facility from the hospital (7/20/23), staffing was increased from 2 to 3 staff on the daytime shifts which were from 9:00 a.m.-5:00 p.m. and 5:00 p.m.-10:00 p.m. on weekdays, and from 9:00 a.m.-8:00 p.m. on weekends. A male staff was scheduled on each shift. This staffing increase was because of Client #3's elopements that occurred during the day.
-"We just don't have the staff to sustain this (staffing) for very long."
-She and QP #1 were filling in as the 3rd staff.
-Client #3 was "still defiant. I tried to have a conversation with him, and he responds with cursing." Her response to this behavior was "Okay, let's give it a minute and calm down because you don't need to curse."
-She denied staff sat outside Client #3's door. The facility was "not a lockdown facility." She could not have someone sit outside Client #3's room "at all times."
-If Client #3 ran away again, the police and his guardian would be notified by staff. She stated "What else can we do? Thought he would be IVC'd (involuntarily committed) and law

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V 112	Continued From page 16 enforcement brought him back." Interviews on 7/19/23, 7/20/23, 7/24/23, and 7/26/23 with QP #1 revealed: -He was notified on 7/19/23 by Staff #3 at approximately 6:20 a.m. that Client #3 wanted to sit in the front seat of the facility van and refused to be redirected to sit in the back seat. -He told Staff #3 not to transport Client #3 to camp "in that state" (defiant). -He notified the camp director that Client #3 would not be attending camp and told Client #3 to "take the day off" (from camp) which led to Client #3's refusal to get off the van and escalated his physical aggression. -"When he heard me on the phone, he became aggressive pulling at the rearview mirror, it broke and Client #3 said he was going to kill himself. Then he was kicking at the windshield causing it to break." -"I have put notice out to his treatment team that we can no longer keep him safe and secure. This was his 5th AWOL (absence without leave) attempt. He needs help at a higher level." -Client #3's treatment plan dated 7/11/23 was from his Care Coordinator, but he (QP #1) developed the short-term goals. He (QP #1) had the 24-hour supervision placed in Client #3's plan because Client #3 was on a 24-hour elopement precaution at his last psychiatric residential treatment facility (PRTF) placement. -After Client #3's first elopement (6/17/23-7/3/23), the facility "beefed up staff" which meant there was 2 staff in the facility when Client #3 was present. -If Client #3 did not meet the IVC criteria, he would be returned to the facility and (staff) did not "know what we'll do if he comes back." -Client #3 was not supervised by facility staff at camp.	V 112		

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V 112	Continued From page 17 -Staff transported Client #3 to camp in the mornings at approximately 6:30 a.m. and transported him back to the facility in the evenings at approximately 6:00 p.m. -He had no response when asked what assessment allowed Client #3 the capability of unsupervised time at camp while he required 24-hour supervision in the facility and to stay within eyesight of staff. -When Client #3 returned to the facility from the hospital on 7/20/23, facility staff increased from 2 to 3 staff on daytime shifts to "keep a closer and more intense check" on Client #3. -If Client #3 was "a little too quiet in his room, staff are to knock on his door and check on him." -He (QP #1) informed Client #3 that he could not attend the camp until further notice because of his elopements, defiance, and a lack of staff. -A staff meeting was scheduled for 7/26/23 to review Client #3's behaviors, his treatment plan and discuss "interval checks (of) every 30 minutes." -Client #3's treatment team meeting was planned for 7/26/23 to discuss whether Client #3 would continue going to camp or not. -Client #3 eloped from his bedroom window on 7/25/23 at 9:28 a.m. after he was told he could no longer attend the camp. "He began cursing, being defiant, and called staff dummies. He was told (by staff) to remain in his room until he calmed down. Staff (not specified) heard a loud sound, and he (Client #3) exited the window ...He was in the driveway and said that if his social worker finds him, tell her to send him back to [his former facility]." -Client #3 was being immediately discharged (7/26/23) because of the "safety risks related to his elopement behavior." Interview on 7/26/23 with the Clinical Director	V 112		

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V 112	Continued From page 18 revealed: -He was aware of Client #3's elopement from his bedroom on the previous day (7/25/23) and his whereabouts were unknown. -Facility staff did not stay with Client #3 at summer camp because he believed the camp staff would "keep eyes" on Client #3. "I know the plan (treatment plan) governs us." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a	V 289		

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V 289	Continued From page 19 developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205(a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).	V 289		

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V 289	Continued From page 20 This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide care and habilitation affecting 1 of 3 clients (#3). The findings are: Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V105). Based on record review and interview, the facility failed to determine their ability to provide services to address the individual needs of 1 of 3 clients (#3). Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111). Based on record review and interview, the facility failed to document strategies to address 1 of 3 clients' (#3) presenting problems prior to the delivery of services. Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review, observation and interview, the facility failed to implement treatment strategies to address the needs for 1 of 3 clients (#3). Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record review and interview, the facility failed to implement policies governing their response to Level II incidents. Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record review and interview, the facility failed to ensure that incident reports were submitted to the Local Management Entity (LME) within 72 hours of becoming aware	V 289 V 289	The Clinical Director's response from the Plan of Protection addresses all the out-of-compliance issues mentioned under V289 - The Compliance Officer will ensure all those involved in the in-take process are educated on our policy and procedures regarding in-take /admission. - The In-Take specialist, the Clinical Supervisor, and Clinical Director shall review every referral, including visits, prior to admission. - Members of the same team shall oversee the reception of all pertinent documents prior to admission, that includes but not limited to the ISP (Individual Service Plan), clinical assessments, doctor's orders, etc. - The Qualified Professional (QP) shall ensure that the plan is being followed accordingly. - The QP shall ensure that all required documentation and data entry Incident Reporting/ GER (General Event Report) is completed, including IRIS (Incident Response Improvement System) reports and T-Logs (staff notes). QP's will be retrained on incident reporting protocols and IRIS submission. - Incidents will continue to be reviewed during QP/clinical meetings as well as during our Human Rights Committee meetings.	07-26-2023

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V 289	Continued From page 21 of the incident. Review on 7/26/23 of the Plan of Protection dated 7/26/23 written and signed by the Clinical Director revealed: "What immediate action will the facility take to ensure the safety of consumers in your care? -The Compliance Officer will ensure all those involved in the in-process are educated on our policy and procedures regarding in-take /admission. -The In-Take specialist, the Clinical Supervisor, and Clinical Director shall review every referral, including visits, prior to admission. -Members of the same team shall oversee the reception of all pertinent documents prior to admission, that includes but not limited to the ISP (Individual Service Plan), clinical assessments, doctor's orders, etc. - The Qualified Professional (QP) shall ensure that the plan is being followed accordingly. -The QP shall ensure that all required documentation and data entry Incident Reporting/GER (General Event Report) is completed, including IRIS (Incident Response Improvement System) reports and T-Logs (staff notes). Describe your plans to make sure the above happens. -The clinical supervisors will review incident report data during clinicals to ensure incident submittal protocol is being followed." The clients residing at this facility were between the ages of 12 and 16 years old with diagnoses that included Autism, Oppositional Defiant Disorder, Attention-Deficit Hyperactivity Disorder and Mood Dysregulation Disorder. Client #3 had a history of prior multiple placements in which his	V 289		

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V 289	Continued From page 22 elopement behavior was an issue. The facility's clinical staff (Qualified Professional #1, Clinical Manager/QP #2 and Clinical Director) knew about Client #3's elopement history prior to his admission, chose to accept responsibility for his care, and did not put strategies in place on admission that addressed his elopement behavior. Client #3 had 5 separate elopement incidents with a total of 17 absent days from the facility within the 1st month of his being admitted. Client #3's second elopement was followed by both a treatment plan and a discharge notice on 7/11/23. Staff did not implement the strategies in Client #3's treatment plan while he was in the facility and at a camp by not providing him with 24-hour staff eyesight supervision and staff did not utilize emergency crisis services when his verbal aggressions escalated to property destruction on at least 2 occasions. Client #3's fifth elopement occurred on 7/25/23 and his whereabouts were unknown on 7/26/23. There was no risk/cause analysis completed by the facility's clinical staff that showed the causes of Client #3's ongoing elopement behavior, what strategies were needed in place that addressed his precipitating behaviors that led him to elope, and what overall treatment services and level of care were needed by Client #3. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT	V 366		

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V 366	Continued From page 23 RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by:	V 366		

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V 366	Continued From page 24 (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and	V 366		

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(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 366	Continued From page 25 (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		
	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement policies governing their response to Level II incidents. The findings are: Review on 7/18/23 of Client #3's record revealed: -Admission date of 6/12/23. -Diagnoses of Autism and Oppositional Defiant Disorder (ODD). -15 years old. Reviews on 7/18/23 and 7/20/23 of facility incident reports for Client #3 revealed: -Incident reports dated 6/17/23 and 7/16/23 did not have documentation that determined the cause(s) of Client #3's elopements, the development and implementation of corrective measures to prevent similar incidents, and an assignment of responsible persons for	V 366	The QP shall ensure that all required documentation and data entry Incident Reporting/GER (General Event Report) is completed, including IRIS (Incident Response Improvement System) reports and T-Logs (staff notes). The QP will ensure that all the required elements of all incident reporting documents are completed entirely.	08-18-2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-666	A. BUILDING: _____ B. WING _____	07/26/2023

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V 366	Continued From page 26	V 366		

implementation of corrective and preventive measures.
-Incident reports dated 7/8/23, 7/16/23 and 7/19/23 and completed by Qualified Professional (QP #1) had no required documentation about staff attending to the health and safety of Client #3, the determined cause for his elopement incidents, the development and implementation of corrective measures to prevent recurrent elopement incidents and assignment of persons responsible to implement corrective and preventive measures.

Interviews on 7/18/23, 7/19/23, 7/20/23, and 7/26/23 with QP #1 revealed:
-"His (Client #3's) pattern is to elope in response to unpreferred activities."
-Client #3's incidences of elopement were:
-1st incident was from 6/17/23 to 7/3/23 (2 weeks) with rumors Client #3 was "couch-surfing" (sleeping on different couches in the community) and he stayed on the streets. He was returned to the facility by his Department of Social Services (DSS) guardian on 7/3/23. Staffing was increased from 1 to 2 staff on each shift when Client #3 was present in the facility.
-2nd incident occurred on 7/8/23 to 7/10/23 (2 days) with his whereabouts unknown and was returned to the facility by a family member. On 7/11/23, he his treatment plan was put into place with "eyesight" supervision, and he was issued a 60-day discharge notice.
-3rd incident was from 7/16/23 to 7/17/23 (1 day) with Client #3 found at a child development center's summer camp he attended as a child. Client #3 was returned to the facility by staff (not named) with an escort from local law enforcement. Client was allowed to attend the summer camp on 7/18/23 as a "volunteer."
-4th incident on 7/19/23 in which Client #3

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V 366	Continued From page 27 eloped from the facility van after he was redirected by staff to sit in the backseat in preparation to be transported to camp and he broke the van windshield. He was located around the mall area by law enforcement. He was taken to a local hospital and evaluated for an involuntary commitment and returned to the facility at his 7/20/23 hospital discharge. -He (QP #1) reviewed "all" internal facility incident reports for Client #3's incidents of elopements. He kept Client #3's treatment team notified of his (Client #3's) incidences of defiant and elopement behaviors and he communicated to the team his concern that Client #3's elopement behaviors were not going to stop. - Client #3 eloped from his bedroom window on 7/25/23 at 9:28 a.m. (5th incident) after he was told he could no longer attend the camp. His whereabouts were unknown. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 366		
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	V 367		

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V 367	Continued From page 28	V 367		

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;
(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

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V 367	Continued From page 29 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 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 that incident reports were submitted to the Local Management	V 367		

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V 367	Continued From page 30 Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident. The findings are: Refer to V366 regarding Client #3's elopement incidents that occurred on 6/7/23, 7/8/23, 7/16/23, 7/19/23 and 7/25/23. Reviews on 7/18/23, 7/20/23, 7/24/23 and 7/26/23 of the Incident Response Improvement System (IRIS) revealed: -No reports for Client #3's incidents of elopement on 6/7/23, 7/8/23, 7/16/23, 7/19/23 and 7/25/23. Interviews on 7/18/23, 7/20/23 and 7/24/23 with the Qualified Professional (QP #1) revealed: -He believed he had completed the process for complete submission of Client #3's incidents into IRIS because he had the confirmation numbers for each report. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 367	The QP shall ensure that all required documentation and data entry Incident Reporting/GER (General Event Report) is completed, including IRIS (Incident Response Improvement System) reports and T-Logs (staff notes) in the time frames indicated for the type of incident.	08-18-2023