STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-148	A. BUILDING: ______ B. WING ______	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTORATIONS	**2211 ROGERS STREET BURLINGTON, NC 27217**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on November 17, 2023. The complaint was substantiated (intake #NC00209085). 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 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients, and 1 former 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	staff will document all bed room alarm checks and document the times The team have updated all goals and will implement using a one-on-one, 7 days a week, awake staff for consumer (S.C.) during the night RECEIVED JAN 29 2024 DHSR-MH Licensure Sect	11/21/23 1/16/24

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement strategies or goals in the treatment/habilitation plan to address continued elopement of 1 of 1 former client (FC#1). The findings are:

Review on 11/14/23 of FC#1's record revealed:
-Admission date of 2/10/22.
-Discharge date of 10/28/23
-Diagnoses of Mild Intellectual Disability, Human Immunodeficiency Virus (HIV), Major Depressive Disorder, and Anxiety Allergic Rhinitis
-Admission Assessment dated 10/11/22: "She doesn't always tell the truth and she has jumped out of her bedroom window to go to parties and at times to get away from her mom's boyfriend."
-Treatment plan dated 2/23/23.
-The facility failed to implement and develop strategies or goals to address the continued elopements of FC# 1.

Review on 11/14/23 of the facility's Incident Reports revealed:
-Incident report dated 10/28/23- "[FC #1] was going to brush her teeth and change her clothes after breakfast. Staff went to check on her, but the bedroom door was locked. When the staff opened the door, [FC#1] had cut off the alarm, and went out the window."
-Incident report dated 10/25/23- "[FC #1] came

Division of Health Service Regulation

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V 112	Continued From page 2 out the bathroom, ran to her bedroom and locked the door. [FC #1] barricaded the door with her bed. When staff finally got into [FC #1's] bedroom, the alarm was cut off and she went out the window." -Incident report dated 10/23/23- "Around 5:30 am staff noticed [FC #1's] bedroom door was closed with the light on. Staff checked on [FC #1] and she had gone out the window." -Incident report dated 7/12/23- "[FC #1] was doing morning care in her room around 6:15am. Staff reports going back to check on her but [FC #1] did not answer when called at 6:30am. Staff notified QP [FC#1"s] bedroom door had been locked by [FC #1]. Staff instructed where to find key. When staff unlocked the door [FC #1] had gone out of the window. Police was called by QP. Backup staff was called as well." -Incident report dated 7/10/23- "[FC #1] left the facility without supervision. [FC #1] waited until staff went to the restroom and went out the front door. Staff reports hearing door alarm and when she entered the front room [FC #1] was gone. Front door was opened. police called and supervisor notified." Interview on 11/16/23 with FC #1 revealed: -"I would sneak out the window when I was upset." -"I would lock my bedroom door, cut off the alarm, and go out the window." -"I would go to a neighborhood down the street from the group home and call the police." -"When the police came to talk to me I would tell lies on [Staff #1] to get her in trouble." -"I ran away from the group home about 3-4 times in the last few weeks." Interview on 11/14/23 with the Residential Manager revealed:	V 112		

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V 112	Continued From page 3 -She completed bedroom checks every hour after 9:00 pm. -She confirmed that she did not document the bedroom checks. -"Anytime [FC #1] was in her bedroom I would do frequent checks." -"Every time [FC #1] would elope I would call the police and [Director/Qualified Professional (D/QP)]." -"[FC #1] did not give any signs when she eloped." Interview on 11/14/23 and 11/16/23 with the D/QP revealed: -Staff did alarm checks and documented the alarm checks for the windows and doors daily. -The alarms had already existed and wasn't put in place due to FC #1 elopement issues. -Staff does bedroom checks every hour, but they did not require staff to document the checks. -Every time FC #1 would elope she would go to the Trailer Park about 7 minutes away from the facility. -FC #1 showed no signs or emotions when she eloped. -The Care Coordinator was assigned to the team in September 2023 to address FC #1 elopement issues. The team had their first meeting October 26, 2023. -In the meeting the team agreed to get FC #1 an updated psychological evaluation, peer support specialist, and an updated comprehensive plan. -She failed to update strategies and goals to address continued elopement issues from FC #1. -"I will ensure staff document all bedroom checks from now on."	V 112		