STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-226	A. BUILDING: _____ B. WING _____	C 07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION POINT	519 UNION STREET SOUTH CONCORD, NC 28025

(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 7-29-24. The complaint was unsubstantiated (intake #NC00217596).A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure For Children Or Adolescents. This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 2 current clients.	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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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 to meet the clients needs affecting 2 of 2 audited clients (client #4 and client #5). The findings are:

Review on 7-25-24 of client #4's record revealed:
-Date of admission: 7-3-2024.
-Age: 16.
-Diagnoses: Post-traumatic Stress Disorder; Adjustment Disorder; Conduct Disorder.
-Comprehensive Clinical Assessment (CCA) dated 7-11-24 documented the following:
-"[Client #4] has a history of elopement and was most recently AWOL (absent without leave) for two weeks (unknown dates). Months prior (unknown dates), he was AWOL for 2 months. Due to this, he is currently seeking placement. Current Living Situation: [Client #4] is currently residing at Turning Point emergency crisis placement Union Point. He was picked up last Tuesday (unknown date) after returning from a 2-week elopement. He states that it is not going well because he feels that staff are judging him "before they get to know me" (regarding his past behaviors and elopement). He reports he has heard staff talking negatively about him and when this occurs it makes him want to elope..."
-Person Centered Plan (PCP) dated 7-8-24 had no goals or strategies to address client #4's

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V 112	Continued From page 2 AWOL behavior. Review on 7-19-24 of NC IRIS (North Carolina Incident Response Improvement System) for the period of April 1, 2024 to July 19, 2024 documented client #4's AWOL on 7-13-24. Unable to interview Client #4 because he was still AWOL at survey exit. Review on 7-22-24 of client #5's record revealed: -Date of admission: 5-8-24. -Age: 17. -Diagnoses: Disruptive Mood Dysregulation Disorder; Unspecified Trauma and Stressor Related Disorder; Conduct Disorder unspecified; Cannabis Dependency uncomplicated. -CCA dated 4-22-24 documenting client #5's history of elopement. -PCP dated 11-20-23 and updated 6-24-24 documented the following: -"5/23/24: On 5/14/24 [client #5] packed a bag and when questioned she expressed that she planned to leave the home (facility). On 5/21/24, [client #5] left the home (facility) without permission; however she returned when picked up by staff (unidentified staff). She was taken to get drug tested and the results came back positive for marijuana." -"6/24/24: On 6/19/24 [client #5] left the home (facility) without permission and went AWOL; however, she was returned the next day (6/20/24) by [Local Police]. She reported to the staff (Qualified Professional/QP) that she was in a car accident. Staff (QP) transported [client #5] to the hospital. During her time of being AWOL, [client #5] was with her child ' s father, and they stole his mother ' s car which is now considered total from the accident." -"On 6/23/24, [client #5] went AWOL with	V 112		

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V 112	Continued From page 3	V 112		

another peer. She returned home on 6/25/24. The treatment team agreed to restrict all community outings until authorized by the social worker (Department of Social Services (DSS) Social Worker) or clinical director. [client #5] phone list has also been limited to her social worker (DSS), GAL (Guardian Ad-Litem), and her sons foster parent and his social worker. It is clinically recommended that [client #5's] level of care is PRTF (Psychiatric Residential Treatment Facility). Moving forward any other infraction will result in immediate removal from the facility."
-No goals or strategies documented in client #5's plan to address client #5's AWOL behaviors.

Review on 7-19-24 of the NC IRIS reports for the period of April, 1, 2024 to July 19, 2024 documented the following AWOL incidents for client #5:
6-19-24, 6-23-24, 7-13-24

Interview on 7-19-24 with client #5 revealed:
-"I've went AWOL about 3 times (since being admitted to the facility). I don't know why. It's something I always do in group homes. I've ran away from every group home I've been in."
-"Staff was here every time. They follow you (client), try to talk you into coming back, stuff like that (staff attempted to prevent client from going AWOL)."
-"No", not working on any goals to address AWOL behaviors.

Interview on 7-19-24 with staff #1 revealed:
-"Yes there have been some AWOL's. If a child (client) goes AWOL and they are within distance (line of sight of staff) and you (staff) have eyesight (have the client in the line of sight), you (staff) can follow them. Once you (staff)lose eyesight we call the non emergency number for

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the police and make a report then call the guardian/DSS (department of social services) and file a report."

Interview on 7-19-24 with staff #2 revealed:
-"Them (clients) running away, that's just something that they will just do. If one of these kids (clients) make up their mind they are going to run, there is nothing you can do to stop them. The protocol is we (staff) follow them until they get out of eyesight and try to talk them into coming back (to the facility). Most of the time we can get them to come back. But once they get out of eyesight we don't follow them any more."

Interview on 7-19-24, 7-22-24 and 7-29-24 with the QP revealed
-2-6-24 the facility opened.: Since the home opened there have been 9 AWOL's.
-"Once we (staff) realize its not them (clients) just blowing off steam, (clients needing to calm down and not leaving the property) we try to keep them in eyesight as much as possible, or for as far as it is safe for staff to do so (during a AWOL staff will follow clients until the client is out of line of sight). Once they are out of line of sight we call the police and let the guardian know."
-"Upon admission, if they (clients) have a AWOL history, we (QP) will go over their (clients) history and their behaviors with the staff. We make sure all the staff are alerted to their (clients) behaviors."
-"We (facility) have a minimum of 3 staff on shift. We have window sensors on all the windows. Movement sensors in the bedrooms (bells that alert the staff when a client comes in or out of their rooms. Window sensors on the bedroom windows connected to [security company], and door chimes on the outside accessible doors."
-"The protocol starts before we get a kid (client).

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V 112	Continued From page 5 It (AWOL protocol) starts with training, we make sure staff know what we are getting (what behaviors a client has before they are admitted). When we look at the referral (application and paperwork received from referral source)..., we interview the client and look at the assessments. We screen (clients) as best as we can. QP's are involved, (in the process/admission/screening process) and should be guiding the services." -"Before a client is admitted we look at their history. We look at each one individually and take it on a case by case basis. We look at how long its been since the last AWOL, why they were AWOL. All that (reasons) is taken into consideration (for admission). If we have concerns (regarding a clients AWOL behavior) we will increase supervion/monitoring (of the client)." -"The behavior, AWOL or other behaviors they (clients) have should be documented. We document (AWOL's) in session notes, incident reports, team meeting notes. Yes, the guardians are involved. The client's guardian gives feedback. If the guardian does not specify they want a goal to address the AWOL we don't put one in (the PCP)" -"After a client has a AWOL, I will discuss the AWOL with them (the client) and try to process their reasoning for leaving. I discuss the safety aspect with them and remind them of things they can do to... coping skills they can use to avoid going AWOL in the future." -"We discuss all AWOL's in the clients CFT (Child and Family Team) meetings. As far as updating the PCP, no (does not update the PCP after an AWOL) unless the team (the guardian) makes a recommendation." Unable to interview Case Manager because she was on vacation.	V 112		

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V 112	Continued From page 6 Interview on 7-29-24 with the Clinical Director revealed: -"A client's AWOL history should be documented in the PCP and they should have a goal that addresses that behavior somewhere in the plan. [QP] can turn it into an intervention (within the PCP) or put it (goal/strategy to address the AWOL behavior) where it makes the most sense. There needs to be a intervention or goal or crisis plan noting the behaviors as part of the clients safety plan. Sometimes it (behavior goal) will be put in the day program part and not in the clients PCP (the facility's PCP) but it needs to be in both. [Case Manager] needs to be doing this (making sure client behaviors are documented in the PCPs) The QP and the Case Manager (lead Case Manager for the the facility) are suppose to work closely with the staff and review client behaviors with the staff. If a new behavior needs to be addressed, it needs to be addressed at the next CFT meeting, which we have regularly."	V 112		