STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-586	A. BUILDING: _____ B. WING _____	C 10/31/2024

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V 000	INITIAL COMMENTS A complaint survey was completed on 10/31/24. The complaint was substantiated (intake #NC00222715. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. This facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 1 current client 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		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement goals and strategies to meet the needs of 1 of 2 audited clients (client #1) and 1 former client (FC #2). The findings are: Review on 10/14/24 of client #1's record revealed: -Admission date of 7/16/24. -17 years old. -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Major Depressive Disorder. -Person Centered Plan updated 9/16/24: "[Client #1] will work with her team to follow the guidelines and rules of the facility and remain in her assigned area without the display of aggressive and/or AWOL (Absent Without Leave)/elopement behaviors at any time 7 out of 7 days per week over the next 30 days." -Goal strategies: "Provide supervision, prompts and redirection as well as positive feedback to [client #1]. Encourage [client #1] to work on her goals in the home and in the community. Help [client #1] identify situations, thoughts, feelings that trigger behavioral actions. Assist [client #1] to identify the positive consequences of managing frustration and anger. Provide modeling positive reinforcement, redirection, de-escalation, guidance, etc. through staff/consumer/peer interactions. Provide	V 112		

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directed/supervised psychoeducational activities including the development and maintenance of daily living, anger management, social, family living, communication, and stress management skills, etc."

Review on 10/14/24 of FC #2's record revealed:
-Admission date of 6/6/24.
-Discharge date of 10/4/24.
-15 years old.
-Diagnoses of Agoraphobia; Adjustment Disorder with mixed disturbance of emotions and conduct, persistent.
-Person Centered Plan updated 9/13/24: "[FC #2] will remain in designated areas 7 out of 7 days and follow rules in the group home."
-Goal Strategies: "Provide supervision, prompts and redirection as well as positive feedback. Model appropriate behavior. Encourage [FC #2] to work on her goal in the home and in the community."

Review on 10/15/24 of the facility's internal incident reports revealed:
-There were no incident reports from 8/1/24 to 10/8/24.

Review on 10/15/24 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-Incidents on 8/24/24, 9/20/24, 10/1/24, and 10/3/24 reporting client #1 AWOL from the facility.
-Incidents on 9/9/24, 9/20/24, 10/1/24, and 10/3/24 reporting FC #2 AWOL from the facility.

Review on 10/15/24 of the local police department call log of calls from the facility from 8/1/21 to 10/8/24 revealed:
-Missing person calls on 8/24/24 ,8/25/24, 9/9/24, 9/14/24, 9/19/24,9/25/24, 9/27/24, 9/30/24, 10/2/24, and 10/3/24.

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V 112	Continued From page 3 Interview on 10/8/24 with client #1 revealed: -"I ran away a couple of times because I got mad but that is it. Just a couple of days. Then I stopped and then I went again." -"I went to [local store] up the road and once went to a friend's house." -"[FC #2] is the reason I kept running away. I used to go (AWOL) with her. She is the reason I used to leave the house without permission. I'm good now." -"Every time we (client #1 and FC #2) run away I left by the door. I always went out the front door." -Denied staff did anything to prevent AWOLs. -"[Staff #2] said, 'be safe.'" -"[House Manager] said, 'Don't come back,' because she got tired of us running away." -"The rest of the staff just called the police." -Went AWOL "mostly" every day. "We (client #1 and FC #2) stayed one day then we ran the next day." -AWOL behavior was happening for "probably ...4 weeks now." -"When we got back (from AWOL) we would be on LOP (loss of privilege)." -LOP meant "You have to do all the chores in the house." Interview on 10/25/24 with FC #2 revealed: -"The whole reason I'm not there (at the facility) is because I kept running away." -"I don't stay where I'm not wanted." -"They (staff) don't care when we leave." -"[House Manager] said that I needed to leave and not come back." -"I wanted to move (to a different facility). I didn't care if I stayed there or not." -"We (client #1 and FC #2) left every day. We went to [local convenience store], [local store], [local grocery store] or my friend's house."	V 112		

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-"We always came back at night."
-"We would be there (in the community without staff) 4 hours and come back (to the facility) to take a break and leave again."
-"It (AWOL) was happening the whole time I have been there (facility)."
-"They (House Manager and staff #2) said if we wanted to leave to go out the front door. We used to go out the window. They said they wouldn't stop us if we went out the front door."
-"They (staff) didn't talk about dangers; the cops did."
-"I ran away about 20 or 30 times (while living at the facility)."
-"We got LOP (extra chores) for 3 days (after AWOL). They didn't make you do them."

Interview on 10/8/24 with client #3 revealed:
-"[Client #1 and FC #2] was going AWOL every day. They were leaving without staff permission."
-"I'm not sure how long (AWOLs had been occurring), about 3 to 4 weeks, maybe the whole month (9/24). It was constantly a lot."
-"Sometimes they would stay out until midnight, sometimes a few hours, sometimes all day."
-"They just walked out the front door."
-"Staff aren't allowed to stop them."
-"I think one time they went out the window in [FC #2's] room."
-There were "not really any consequences. They put them on LOP. Do chores, not allowed to go out and do stuff, not allowed to watch TV."

Interview on 10/8/24 and 10/30/24 with staff #1 revealed:
-"[Client #1 and FC #2] have been running pretty much every night. Jumping out of windows and going out the door."
-"We (staff) just give a speech (about dangers of AWOL) every now and then but they don't listen."

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-"We call the police and they handle everything. Find them (client #1 and FC #2), bring them back, search them and we go from there. They go in their rooms and tear it up and pack their bags and go again."
-"It is like hide and seek."
-Consequence for AWOL is loosing electronics "for 3 days, but this is happening every day so we can't keep track of that."
-"What can we do (to prevent AWOL)? Goals are never met."
-"Basically we don't have any strategies. She (client #1) was doing it because of the other teenager (FC #2), like peer pressure."
-"We can't force them to stay if they don't want."
-"She (FC #2) was just walking out the door without asking. We notified the police to let them know they are out there (AWOL)."
-"We couldn't talk to them (client #1 and FC #2) because they went out so fast."

Interview on 10/23/24 and 10/30/24 with staff #2 revealed:
-"I lost count of how many times they (client #1 and FC #2) ran. The last week (week of 9/9/24) the police told me we had called in (to report AWOL) 25 times."
-AWOLs "started in September. They (client #1 and FC #2) started going AWOL like it was nobody's business. Just about every day. Sometimes they would go 2 or 3 times in a day."
-"We tried to talk to them (client #1 and FC #2) about the dangers and the risk out there. It didn't bother them. You got cussed out in the process. I always tell them about the dangers. They think they are invincible."
-"There is consequences already in place (LOP), but they (client #1 and FC #2) knew they could circumvent that by doing nothing."
-"We (staff) can't make them (client #1 and FC

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#2) stay in the house. We can't lock them in. It would benefit them to keep them safe. All we can do is talk to them."
-"They (client #1 and FC #2) were just walking out the front door. A couple of times they jumped out the window. I told them not to jump because they could get hurt. They just walked out the door. Sometimes they tried to sneak out, a lot of times they threw their 2 fingers up like, 'Dufus I'm out.'"
-"I tried to communicate with her (client #1) about the dangers out there ...child trafficking that would put her in danger. She might learn from it later, but it didn't appear that she was getting anything from it at the time."
-"Sometimes she (FC #2) jumped out the window. I told her not to jump because she could break an ankle or wrist."
-"They (client #1 and FC #2) felt that they were not getting any consequences and they could come and go as they please."
-"I tried to talk to them (client #1 and FC #2) as they were leaving. They kept going."
-"Interventions were given, but we couldn't keep them (client #1 and FC #2) here."
-"I never told them it is ok to go."
-Denied telling client #1 and FC #2 not to come back.

Interview on 10/25/24 and 10/30/24 with staff #3 revealed:
-"They (client #1 and FC #2) were consistently running."
-"[FC #2] was running. [Client #1] was following."
-"They (client #1 and FC #2) were constantly going and coming over about a 30 day period, after school started. If not every day, every other. Almost every day."
-"There were no serious consequences."
-"The police were getting frustrated because as soon as they brought them (client #1 and FC #2)

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back they would get another call."
-"One day we went to the library and had the perfect day, and when we got back they (client #1 and FC #2) just walked out the door. With only 1 staff there is only so much you can do."
-Changes such as "securing doors more ...keeping them busy. It was counterproductive."
-"We structured it as much as we could. Even with 2 staff they would have still walked out. It didn't matter."
-"I tried to talk to them when they were not running about the dangers of being out without an adult. Reminded them of the consequences ...Human trafficking ...Give them reminders when they were not running."
-"We could have done more if we had 2 staff."
-"There was no consequences."

Interview on 10/23/24 with the House Manager revealed:
-"On a daily basis (since August) both of the girls (client #1 and FC #2) left 2 or 3 times a day."
-"As far as calling the police it has probably been about 25 times (that client #1 and FC #2 were reported missing) if I am not mistaken. The police have gotten agitated with the situation. The officer called about how many times they (police) have been called."
-To prevent AWOL, "we incorporated activities. I started being in the house more ...to see if it would change up the pattern. The only thing that changed was when (time of day) they would go AWOL."
-"With these ladies, it was (client #1 ran) when [FC #2] was ready to go."
-"[Client #1] was the follower."
-"They (client #1 and FC #2) would eat dinner and pretend they were going to bed and march out the door."
-"With others (staff) they (client #1 and FC #2)

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V 112	Continued From page 8 would take food and walk out." -"They (client #1 and FC #2) would walk through (living room) and run out the front door." -"Staff were supposed to watch until they were not seen anymore." -Denied telling client #1 and FC #2 not to come back. Interview on 10/25/24 with the Clinical Director revealed: -"I got email notifications or follow-up phone calls when clients went AWOL." -Was only aware of AWOL incidents that were reported through IRIS. -"[FC #2] was placed on 30 day notice. With her out, [client #1] would stabilize." -"Usually with 3 AWOLs we assess for safety and look for other placement options." -" With [client #1] we did not do a 30 day notice. Once [FC #2] was gone we could better assess needs." -Client #1 and FC #2 had AWOL goals and strategies in their plans." -"If they didn't have AWOL goals we would have added one." -"Consequences were LOP, no community outings. They were going so much it was hard to stick to consequences."	V 112		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT 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	V 366		

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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:
(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

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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

(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

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V 366	Continued From page 11 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies governing their response to level II incidents as required. The findings are: Review on 10/15/24 of the facility's internal incident reports revealed: -There were no incident reports from 8/1/24 to 10/8/24. Review on 10/15/24 of the North Carolina Incident Response Improvement System (IRIS) for the dates 8/1/24 to 10/8/24 revealed: -Incidents on 8/24/24, 9/20/24, 10/1/24, and 10/3/24 reporting client #1 AWOL (Absent Without Leave) from the facility. -Incidents on 9/9/24, 9/20/24, 10/1/24, and 10/3/24 reporting FC #2 AWOL from the facility. -No Reports or risk cause analysis for AWOL behaviors for client #1 and FC #2 for 8/24/24, 8/25/24, 9/14/24, 9/19/24, 9/25/24, 9/27/24, 9/30/24, and 10/2/24. Review on 10/15/24 of the local police department call log of calls from the facility from	V 366		

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V 366	Continued From page 12 8/1/21 to 10/8/24 revealed: -Missing person calls on 8/24/24, 8/25/24, 9/9/24, 9/14/24, 9/19/24, 9/25/24, 9/27/24, 9/30/24, 10/2/24, and 10/3/24. Interview on 10/8/24 with client #1 revealed: -"I ran away a couple of times because I got mad but that is it. Just a couple of days. Then I stopped and then I went again." -"I went to [local store] up the road and once went to a friend's house." -"[FC #2] is the reason I kept running away. I used to go (AWOL) with her. She is the reason I used to leave the house without permission. I'm good now." -"[Staff #2] said, 'Be safe.'" -"[House Manager] said, 'Don't come back,' because she got tired of us running away." -"The rest of the staff just called the police." -Went AWOL "mostly" every day. "We stayed one day then we ran the next day." -AWOLs were happening for "probably ...4 weeks now." -Did not know specific dates AWOLs occurred. -"The police brought us back or we came on our own. They (staff) reported us to the missing hotline and the police brought us back in f*****g handcuffs." Interview on 10/25/24 with FC #2 revealed: -"The whole reason I'm not there (at the facility) is because I kept running away." -"I don't stay where I'm not wanted." -"They (staff) don't care when we leave." -"[House Manager] said that I needed to leave and not come back." -"I wanted to move (to a different facility). I didn't care if I stayed there or not." -"We left every day. We went to [local convenience store], [local store], [local grocery	V 366		

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store] or my friend's house."
-"We (client #1 and FC #2) always came back at night."
-"We would be there (in the community without staff) 4 hours and come back (to the facility) to take a break and leave again."
-"The cops always bring us home."
-"They (staff) didn't talk about dangers, the cops did."
-"I ran away about 20 or 30 times."
-Did not know specific dates AWOLs occurred.

Interview on 10/8/24 with client #3 revealed:
-"[Client #1 and FC #2] was going AWOL every day. They were leaving without staff permission."
-"I'm not sure how long (AWOLs had been occurring), about 3 to 4 weeks, maybe the whole month. It was constantly a lot."
-"Sometimes they [client #1 and FC #2] would stay out until midnight, sometimes a few hours, sometimes all day."
-Did not know specific dates AWOLs occurred for client #1 and FC #2.

Interview on 10/8/24 and 10/30/24 with staff #1 revealed:
-"[Client #1 and FC #2] have been running pretty much every night. Jumping out of windows and going out the door."
-"I can't recall (how many times client #1 and FC #2 went AWOL). You can't count it."
-"We call the police and they handle everything. Find them (client #1 and FC #2), bring them back, search them and we go from there. They go in their rooms and tear it up and pack their bags and go again."
-"It is like hide and seek."
-"After 15 or 20 minutes (of client #1 and FC #2 leaving the facility) we would notify the police. They came back within 2 or 3 hours every time. I

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let the police know where they always went ... [grocery store] or the gas station."
-"Sometimes they came back on their own. Sometimes the police brought them back."
-"Every time they leave we write an incident report. We send them to management (the House Manager). I do that every time they leave on my shift."
-Did not know specific dates AWOLs occurred for client #1 and FC #2.

Interview on 10/23/24 and 10/30/24 with staff #2 revealed:
-"I lost count of how many times they (client #1 and FC #2) ran. The last week (week of 9/9/24) the police told me we had called in (to report AWOL) 25 times."
-AWOLs "started in September. They (client #1 and FC #2) started going AWOL like it was nobody's business. Just about every day. Sometimes they would go 2 or 3 times in a day."
-"They (client #1 and FC #2) were just walking out the front door. A couple of times they jumped out the window. I told them not to jump because they could get hurt. They just walked out the door. Sometimes they tried to sneak out, a lot of times they threw their 2 fingers up like, 'Dufus I'm out.'"
-We tried to give them enough time to go before we called the police.
-We gave them from 30 minutes to an hour to go and come back.
-"When they (client #1 and FC #2) ran, I notified the House Manager, she calls the social worker, and we call [local police department] to do a report."
-"I called the police every time they went. Sometimes they would leave again before we could do the recovery."
-When they (client #1 and FC #2) arrive back at the house we have to call the police to make sure

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they don't have weapons or contraband."
-"We do it (incident report) on a paper sheet. It is given to the House Manager, and she turns it in (to the office)."
-"Initially (first time client #1 and FC #2 ran for the day) we did one (incident report). But not always if they ran more than once in a day. There should be one (incident report) for every day they ran. I don't know the exact dates."

Interview on 10/25/24 and 10/30/24 with staff #3 revealed:
-"They (client #1 and FC #2) were consistently running."
-"[FC #2] was running. [Client #1] was following."
-"They (client #1 and FC #2) were constantly going and coming over about a 30 day period, after school started. If not every day, every other. Almost every day."
-"The police were getting frustrated because as soon as they brought them (client #1 and FC #2) back they would get another call."
-"At night they (client #1 and FC #2) were gone 3-4-5 hours. Go and come back and leave back out."
-"The policy is after 20 minutes (of being out of sight) we call the police. We notify the supervisor (House Manager) immediately and wait 20 minutes to call the police."
-"We (staff) would call the police and do the incident report ...I always did an incident report."
-"[House Manager] picked up the paper version of the report and took it to the office. We (staff) fill it out and I'm not sure what happens to it next."
-"[House Manager] or [Clinical Director] is responsible for deciding the level (of the incident)."
-Did not know specific dates AWOLs occurred for client #1 and FC #2.

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V 366	Continued From page 16 Interview on 10/23/24 with the House Manager revealed: -"On a daily basis, (since August) both of the girls (client #1 and FC #2) left 2 or 3 times a day." -"On average, some nights it would be 2 hours, some 5 or 6 hours (that client #1 and FC #2 were AWOL). Sometimes they would come back at about 4 or 5 in the morning." -"As far as calling the police it has probably been about 25 times (that client #1 and FC #2 were reported missing) if I am not mistaken. The police have gotten agitated with the situation. The officer called about how many times they (police) have been called." -"Staff were supposed to watch until they were not seen anymore." -"After about 30 minutes if they (client #1 and FC #2) come back they (staff) just let me know (and did not complete an incident report)." -"We just consider it (leaving the facility for a short period of time) a walk down time." -"A short amount of time (away from staff supervision), up to 45 minutes is a walk off." -Did not document "walk offs." -"We don't let the guardians know for the short ones (walking off and cooling down)." -"Anything over an hour we do a level 1 incident report if the police do not generate a missing person report." -"If they (police) do a missing person report they (Quality Assurance/Quality Improvement (QA/QI) Director) put them in the IRIS system." -[QA/QI Director] completes IRIS. I send her an email. If the police are involved in any way, I usually do send her a message." -Did not know specific dates AWOLs occurred for client #1 and FC #2. Interview on 10/25/24 with the Clinical Director revealed:	V 366		

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V 366	Continued From page 17 -"I got email notifications or follow-up phone calls when clients went AWOL." -Was only aware of AWOL incidents that were reported through IRIS. -"The policy is to try to keep line of sight for 15 minutes, then call the police. Within 24 hours notify myself and the legal guardian every time they are gone more than 15 minutes." -"If I don't get the report (internal AWOL incident report), I don't know they went AWOL and it doesn't trigger an IRIS report." -"Staff are expected to fill out an incident report. [House Manager] gets it to myself and [QA/QI Director]. [QA/QI Director] determines when an IRIS needs to be done." -"Any police contact or hospitalization would be an IRIS." Interview on 10/25/24 with the Quality Assurance/Quality Improvement (QA/QI) Director: -"[House Manager] is responsible for getting incident reports to me, and I review and complete IRIS if needed." -"The AWOL policy is to wait 15 minutes and then call [the local police department]. Call Manager and Clinical Director." -"Staff complete the report and [House Manager] brings it to the office." -"We (Clinical Director and QA/QI Director) determine the level of the incident." -"If they (clients) leave (supervision) it should be an incident report." -"All running with police involved is a level 2 (incident)." -"The only time the police would not be involved is if it is less than 15 minutes. If it was more than 15 minutes the police would be called." -Did not submit IRIS reports, complete a risk cause analysis, or notify the LME/MCO for all the dates that the police were involved for client #1	V 366		

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V 366	Continued From page 18 and FC#2's AWOL behavior (8/24/24, 8/25/24, 9/14/24, 9/19/24, 9/25/24, 9/27/24, 9/30/24, and 10/2/24).	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 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	V 367		

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information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the 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

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V 367	Continued From page 20 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 report level II incidents in the Incident Response Improvement System (IRIS) within 72 hours of becoming aware of the incident. The findings are: Review on 10/15/24 of the North Carolina Incident Response Improvement System (IRIS) for the dates 8/1/24 to 10/8/24 revealed: -No reports found for incidents of AWOL for client #1 and FC #2 for 8/24/24, 8/25/24, 9/14/24, 9/19/24, 9/25/24, 9/27/24, 9/30/24, and 10/2/24. Review on 10/15/24 of the local police department call log of calls from the facility from 8/1/21 to 10/8/24 revealed: -Missing person calls on 8/24/24, 8/25/24, 9/9/24, 9/14/24, 9/19/24, 9/25/24, 9/27/24, 9/30/24, 10/2/24, and 10/3/24. Interview on 10/8/24 with client #1 revealed: -"I ran away a couple of times because I got mad but that is it. Just a couple of days. Then I stopped and then I went again."	V 367		

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-"I went to [local store] up the road and once went to a friend's house."
-"[FC #2] is the reason I kept running away. I used to go (AWOL) with her. She is the reason I used to leave the house without permission. I'm good now."
-"The rest of the staff just called the police."
-Went AWOL "mostly" every day. "We stayed one day then we ran the next day."
-Did not know specific dates AWOLs occurred.
-"The police brought us back or we came on our own. They (staff) reported us to the missing hotline and the police brought us back in f*****g handcuffs."

Interview on 10/25/24 with FC #2 revealed:
-"The whole reason I'm not there (at the facility) is because I kept running away."
-"I don't stay where I'm not wanted."
-"I wanted to move (to a different facility). I didn't care if I stayed there or not."
-"We (client #1 and FC #2) left every day. We went to [local convenience store], [local store], [local grocery store] or my friend's house."
-"We (client #1 and FC #2) always came back at night."
-"We would be there (in the community without staff) 4 hours and come back (to the facility) to take a break and leave again."
-"The cops always bring us home."
-"I ran away about 20 or 30 times."
-Did not know specific dates AWOLs occurred.

Interview on 10/8/24 with client #3 revealed:
-"[Client #1 and FC #2] was going AWOL every day. They were leaving without staff permission."
-"I'm not sure how long (AWOLs had been occurring), about 3 to 4 weeks, maybe the whole month. It was constantly a lot."
-"Sometimes they [client #1 and FC #2] would

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stay out until midnight, sometimes a few hours, sometimes all day."
-Did not know specific dates AWOLs occurred for client #1 and FC #2.

Interview on 10/8/24 and 10/30/24 with staff #1 revealed:
-"[Client #1 and FC #2] have been running pretty much every night. Jumping out of windows and going out the door."
-"I can't recall (how many times client #1 and FC #2 went AWOL). You can't count it."
-"We call the police and they handle everything. Find them (client #1 and FC #2), bring them back, search them and we go from there. They go in their rooms and tear it up and pack their bags and go again."
-"It is like hide and seek."
-"After 15 or 20 minutes (of client #1 and FC #2 leaving the facility) we would notify the police. They came back within 2 or 3 hours every time. I let the police know where they always went ... [grocery store] or the gas station."
-"Sometimes they came back on their own. Sometimes the police brought them back."
-"Every time they leave we write an incident report. We send them to management (the House Manager). I do that every time they leave on my shift."
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-"I lost count of how many times they (client #1 and FC #2) ran. The last week (week of 9/9/24) the police told me we had called in (to report AWOL) 25 times."
-AWOLs "started in September. They (client #1 and FC #2) started going AWOL like it was

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nobody's business. Just about every day. Sometimes they would go 2 or 3 times in a day."
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-We tried to give them enough time to go before we called the police.
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-"I called the police every time they went. Sometimes they would leave again before we could do the recovery."
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-"We (staff) do it (incident report) on a paper sheet. It is given to the House Manager, and she turns it in (to the office)."
-"Initially (first time client #1 and FC #2 ran for the day) we did one (incident report). But not always if they ran more than once in a day. There should be one (incident report) for every day they ran. I don't know the exact dates."

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-"They (client #1 and FC #2) were consistently running."
-"They (client #1 and FC #2) were constantly going and coming over about a 30 day period, after school started. If not every day, every other. Almost every day."
-"The police were getting frustrated because as

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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 367	Continued From page 24	V 367		

soon as they brought them (client #1 and FC #2) back they would get another call."
-"At night they (client #1 and FC #2) were gone 3-4-5 hours. Go and come back and leave back out."
-"The policy is after 20 minutes (of being out of sight) we call the police. We notify the supervisor (House Manager) immediately and wait 20 minutes to call the police."
-"We (staff) would call the police and do the incident report ...I always did an incident report."
-"[House Manager] picked up the paper version of the report and took it to the office. We (staff) fill it out and I'm not sure what happens to it next."
-"[House Manager] or [Clinical Director] is responsible for deciding the level (of the incident)."
-Did not know specific dates AWOLs occurred for client #1 and FC #2.

Interview on 10/23/24 with the House Manager revealed:
-"On a daily basis, (since August) both of the girls (client #1 and FC #2) left 2 or 3 times a day."
-"On average, some nights it would be 2 hours, some 5 or 6 hours (that client #1 and FC #2 were AWOL). Sometimes they would come back at about 4 or 5 in the morning."
-"As far as calling the police it has probably been about 25 times (that client #1 and FC #2 were reported missing) if I am not mistaken. The police have gotten agitated with the situation. The officer called about how many times they (police) have been called."
-"Staff were supposed to watch until they were not seen anymore."
-"After about 30 minutes if they (client #1 and FC #2) come back they (staff) just let me know (and did not complete an incident report)."
-"We just consider it (leaving staff supervision for

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	MHL060-586	A. BUILDING: _____ B. WING _____	C 10/31/2024

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a short period of time) a walk down time."
-"A short amount of time (away from staff supervision), up to 45 minutes is a walk off."
-Did not document "walk offs."
-"We don't let the guardians know for the short ones (walking off and cooling down)."
-"Anything over an hour we do a level 1 incident report if the police do not generate a missing person report."
-"If they (police) do a missing person report they (Quality Assurance/Quality Improvement (QA/QI) Director) put them in the IRIS system."
-[QA/QI Director] completes IRIS. I send her an email. If the police are involved in any way, I usually do send her a message."
-Did not know specific dates AWOLs occurred for client #1 and FC #2.

Interview on 10/25/24 with the Clinical Director revealed:
-"I got email notifications or follow-up phone calls when clients went AWOL."
-Was only aware of AWOL incidents that were reported through IRIS.
-"The policy is to try to keep line of sight for 15 minutes, then call the police. Within 24 hours notify myself and the legal guardian every time they are gone more than 15 minutes."
-"If I don't get the report (internal AWOL incident report), I don't know they went AWOL and it doesn't trigger an IRIS report."
-"Staff are expected to fill out an incident report. [House Manager] gets it to myself and [QA/QI Director]. [QA/QI Director] determines when an IRIS needs to be done."
-"Any police contact or hospitalization would be an IRIS."

Interview on 10/25/24 with the Quality Assurance/Quality Improvement (QA/QI) Director:

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V 367	Continued From page 26 -"[House Manager] is responsible for getting incident reports to me, and I review and complete IRIS if needed." -"The AWOL policy is to wait 15 minutes and then call [the local police department]. Call Manager and Clinical Director." -"Staff complete the report and [House Manager] brings it to the office." -"We (Clinical Director and QA/QI Director) determine the level of the incident." -"If they (clients) leave (supervision) it should be an incident report." -"All running with police involved is a level 2 (incident)." -"The only time the police would not be involved is if it is less than 15 minutes. If it was more than 15 minutes the police would be called." -Did not complete Level II IRIS reports or notify the LME/MCO writing 24 hours for all the dates that the police were involved for client #1 and FC#2's AWOLs (8/24/24, 8/25/24, 9/14/24, 9/19/24, 9/25/24, 9/27/24, 9/30/24, and 10/2/24).	V 367		