PRINTED: 03/18/2025
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL076-063	A. BUILDING: _____ B. WING _____	R 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUTH UNLIMITED-SLANE HOME	2872 YOUTH UNLIMITED DRIVE SOPHIA, NC 27350

(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, complaint and follow up survey was completed on March 7, 2025. The complaints were substantiated (Intake #NC00227587 and #NC00228003). Deficiencies were 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 four and has a current census of four. The survey sample consisted of audits of three current clients.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use.	V 114	Moving forward the Clinical Director will review fire drills each month at the Agency Level Meetings to ensure compliance with regulations. Please keep in mind that the Slane House was not open in July or August.	04/05/2025

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DHSR-MH Licensure Sect

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Frank Mullis | TITLE: Executive Director | (X6) DATE: 3/24/25

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V 114	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire and disaster drills were completed quarterly on each shift. The findings are: Review on 2/25/25 of the facility's fire and disaster drill log from (January 2024- January 2025 revealed: -There were no fire drills conducted for the 1st, 2nd and 3rd shifts during the 3rd quarter (July, August, September) of 2024. -There were no disaster drills conducted for the 1st, 2nd and 3rd shifts during the 3rd quarter (July, August, September) of 2024. Interview on 2/27/25 with client #1 revealed: -They have drills once a month. -He could not recall if drills were fire, disaster or both. Interview on 2/27/25 with client #2 revealed: -He had not completed a fire or disaster drill since living in the facility. Interview on 2/27/25 with client #3 revealed: -He could not recall if had participated in a fire or disaster drill since he was admitted to the facility. Interview on 2/27/25 with staff #1 revealed: -She was employed with the agency for close to a year. -She previously worked third shift upon hire and now worked second shift. -She had not completed a fire or disaster drill on any shifts that she has worked.	V 114		

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V 114	Continued From page 2 Interview on 3/3/25 with the Clinical Director revealed: -To her knowledge, staff were to complete drills monthly on each shift. -The House Director was responsible for ensuring that fire and disaster drills were completed in the facility. -Acknowledged the facility failed to ensure the fire and disaster drills were completed quarterly on each shift.	V 114		
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A P 10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and (3) participation in service planning meetings.	V 295	We have been working on upgrading the staff. We increased pay considerably to attract more experienced people. We have hired an AP to be a floater who can step in if someone calls out at the last minute to ensure consistency in the house.	05/07/2025

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V 295	Continued From page 3 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to employ an Associate Professional (AP) who provided services to the group home on a full-time basis. The findings are: Review on 3/6/25 of the Associate Professional personnel record revealed: -Date of hire was 10/11/24. -Hired as a Residential Counselor. -There was documentation of a bachelor's degree and years of experience. Interview on 3/6/25 with the Clinical Director revealed: -Staff #6 replaced Former Staff #7 as of February 14, 2025 as the Associate Professional. -Staff #6 worked second shift during the weekday. -She thought staff #6 had a four-year degree. -Acknowledged the facility did not have a full time AP that worked on a full-time basis in the group home. This deficiency has been cited 3 times since the original cite on 2/27/24 and must be corrected within 30 days.	V 295		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff	V 296	We are upgrading our staff. We were aware we had some staffing issues due to having terminated three employees abruptly, but were actively pursuing new hires before that happened. We have hired and started three new people including a full time AP for Slane.	04/07/2025

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V 296	Continued From page 4 required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.	V 296	We hired and continue to hire additional staff for nights.	

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V 296	Continued From page 5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the minimum number of direct care staff was present and awake. The findings are: Review on 2/25/25 of client #1's record revealed: -Admitted on 1/23/25. -Diagnosis of Post Traumatic Stress Disorder. -He was 17 years old. Review on 2/25/25 of client #2's record revealed: -Admitted on 1/10/25. -Diagnoses of Post Traumatic Stress Disorder and Major Depressive Disorder. -He was 17 years old. Review on 2/25/25 of client #3's record revealed: -Admitted on 2/3/25. -Diagnoses of Major Depressive Disorder-Recurrent/Unspecified, Generalized Anxiety Disorder and Attention Deficit Hyperactivity Disorder- predominantly inattentive presentation. -He was 13 years old. Review on 2/26/25 of the Incident Response Improvement System (IRIS) reports dated 2/17/25 for an incident on 2/14/25 revealed: -"Client (client #1) along with two other clients (client #2 and client #3) stole key for agency van and absconded. Staff alerted authorities and guardian. Client (client #1) was located in [city one hour six minutes away and 59.4 miles away]. Staff picked up client and returned to residential setting on 2/15/25." -Client (client #1) took the agency van. Client	V 296		

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V 296	Continued From page 6 (client #2) was along for the ride while absconding from facility with two other clients (client #1 and client #3). Staff picked client up on 2/15/25 and returned to the facility." -Client (client #1) with other clients (client #2 and #3) stole the agency van and absconded. Clients were found in city one hour six minutes away and 59.4 miles away]. Staff picked up client and returned to residential setting (facility) on 2/15/25. Interview on 2/27/25 with client #1 revealed: -He was upset that staff said they had to go the hospital because the staff were leaving. -When Former Staff #7 and Former Staff #8 left the facility, the Clinical Director was the only staff working the shift. -"I saw staff left the key on the table and I took it." -"I have a history of stealing cars." -He was currently on probation. -He had not completed any driver's education training. -He was the driver of the van. -"We all planned to leave during third shift once I had got the key." -He went to bed, climbed out the window and got in the van and left with client #2 and client #3 around 9:30pm. -"We were just hanging out and driving around." -"The van totaled." -"We had the right away and I was turning left at a green light and a F250 truck T-boned us." -He had a blister on his wrist from the deployment of the airbag and his body was sore. -He was picked up by the police and taken into custody. -He was released back to facility staff the next day as there was no space in the detention center. Interview on 2/27/25 with client #2 revealed:	V 296		

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V 296	Continued From page 7 -"[Former Staff #7] said they were taking us to the hospital if staff did not call back and answer her questions." -"I was upset the staff were quitting." -The staff left the key on the table and client #1 took the key. - He went to bed, climbed out the window and got in the van and left with client #1 and client #3 around 9:30pm. -He was in the front seat in the van. -"We went to my former foster family house in [city one hour six minutes away and 63.7 miles away]." -"We were just riding around and had no plan to return to the facility." -I had closed my eyes and heard client #1 say 'oh s**t' and then felt the van get hit." -His body was sore but he didn't have any injuries. -The police picked them up and held them. -The next day they were picked up by the facility staff and returned back to the facility. Interview on 2/27/25 with client #3 revealed: -"I wanted to leave as I was missing my family." -They all decided to leave the facility on the van once they went to bed. -He went to bed, climbed out the window and got in the van and left with client #1 and client #2 around 9:30pm. -He laid down and slept during the ride. -He awakened at the impact of the van when hit by the truck. -"I actually raised up off the seat when we were hit." -His body was sore but he didn't have any injuries. -"The police came and picked us up." -The next day they were picked up by the facility staff and returned back to the facility.	V 296		

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V 296	Continued From page 8 Interview on 2/26/25 with staff #3 revealed: -She had worked first shift the day the clients eloped from the facility. -She recalled that day the staff did the school run and she saw the keys on the dining room table. -The vehicle key was supposed to be kept upstairs. -She received a call from the Clinical Director to communicate with Former Staff #8 they were scheduled to work in another facility for the weekend. -She contacted Former Staff #8 as instructed. -She was later informed by the Clinical Director about the incident that occurred regarding the elopement of the clients on 2/14/25. Interview on 2/26/25 with Former Staff #7 revealed: -She was working her scheduled shift the day of the clients' elopement and quit. -She was "fed up" with how things operated in the facility. -She left a message with the Clinical Director that she can go to the local hospital to get the clients as she and Former Staff #8 were leaving. -The clients became upset. -The Clinical Director arrived on shift and stated she and Former Staff #8 were fired. -"I told her (Clinical Director) I quit and that she could not fire me." -"The clients were still in the facility when I left." -When she was leaving, the Clinical Director came to her to ask if the key on the dining room table was her key and she confirmed that was not her key. -"The facility key to the van was supposed to be in a green cabinet upstairs, but they were always out." -There were no other staff on shift with the	V 296		

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V 296	Continued From page 9 Clinical Director when she and Former Staff #8 left the facility at 7:59pm. Interview on 2/27/25 with the Clinical Director revealed: -She received several texts from Former Staff #7 inquiring about the reassignment of Former Staff #8. -She proceeded to go to the facility and upon arrival planned to terminate both staff of their work duties due their unprofessional conduct. -She was the only staff on shift once the terminated staff left the facility. -She planned to work the shift for the weekend with the other scheduled staff. -She saw the key on the dining room table and asked Former Staff #7 if the key belonged to her and she stated no. -"I thought nothing about it being the facility van key." -She prompted all the clients to prepare for bed. -Client #1, #2 and #3 were huddled together and made no eye contact with me. -"They all willingly went to bed." -She did a bedroom check within 10 minutes and saw that client #1, client #2 and client #3 were not in their respective bedrooms and the windows were open. -"I immediately contacted the police to make a report." -The police arrived and requested information for the clients. -One of the officers inquired how many vehicles were in the driveway. -She stated the facility van and her personal vehicle were in the driveway. -The police officer made her aware the facility van was gone. -The police officer made a call to alert for the facility van.	V 296		

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V 296	Continued From page 10 -She received a call from an officer around 12:30am that the clients were located and taken into custody. -All the clients were returned to the facility on 2/15/2025. -She was also informed by the officer the clients were in an accident and were T-boned by a large pick up truck. -She did not think about calling in additional staff to work during the shift until the arrival of the third shift staff. -She was the only staff on shift from 8pm until the third shift staff arrival at 10pm. Review on 3/6/25 of a Plan of Protection written by the Clinical Director dated 3/6/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? We have increased our salaries in order to attract better candidates. We are going to have a shift "floater" who will have Qualified Professional qualifications but be hired as an Associate Professional in order to ensure we have an extra person on campus for when someone calls out does not show up, or leaves before their shift is over. We put all the car keys on lanyards so staff has no excuse to leave keys laying around. Describe your plans to make sure the above happens. We have 4 potential staff members working on completing hiring process. We are screening the candidates we are seeing to ensure they have the proper attitude and demeanor to work with children in an appropriate manner. We are working on rewriting all our trainings to bring them up to date and are scheduling mandatory quarterly training for all full-time staff. We are putting a Master level intern program to help us beef up the training classes to make them more effective, engaging and meaningful. We will	V 296		

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V 296	Continued From page 11 increase the information we give our staff in the home to identify behaviors and issues so the staff have more knowledge about the clients when they come in." Client #1, client #2 and client #3 ranged in age from 13 to 17 years old and were diagnosed with Post Traumatic Stress Disorder, Major Depressive Disorder and Generalized Anxiety Disorder and Attention Deficit Hyperactivity Disorder- predominantly inattentive presentation. All three clients eloped from the facility on 2/14/25. On 2/14/25 the facility terminated Former Staff #7 and Former Staff #8 during their shift leaving the facility below the required minimum staff coverage with the Clinical Director being the only person working in the facility with four clients. During that evening the clients had taken the facility van key, that were unsecured and laying on the dining room table. The clients had taken the facility van and were involved in an accident 63.7 miles away from the facility with a large pickup truck. The driver had no driver's education training. The clients had minor bruises and injuries from the accident. The clients were arrested and released back to the facility on 2/15/25. This deficiency constitutes a Continuing Type A1 rule violation originally cited for serious neglect and failure to correct within 23 days.	V 296		
V 297	27G .1705 Residential Tx. Child/Adol - Req. for L P 10A NCAC 27G .1705 REQUIREMENTS OF LICENSED PROFESSIONALS (a) Face to face clinical consultation shall be provided in each facility at least four hours a	V 297	As Clinical Director, I have resumed individual therapy. The intern will do psycho-educational groups and observe therapy when appropriate.	Completed

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V 297	Continued From page 12 week by a licensed professional. For purposes of this Rule, licensed professional means an individual who holds a license or provisional license issued by the governing board regulating a human service profession in the State of North Carolina. For substance-related disorders this shall include a licensed Clinical Addiction Specialist or a certified Clinical Supervisor. (b) The consultation specified in Paragraph (a) of this Rule shall include: (1) clinical supervision of the qualified professional specified in Rule .1702 of this Section; (2) individual, group or family therapy services; or (3) involvement in child or adolescent specific treatment plans or overall program issues. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure face to face clinical consultation was provided in the facility at least four hours a week by a Licensed Professional (LP). The findings are: Review on 2/25/25 of client #1's record revealed: -17 year old male. -Admitted on 1/23/25. -Diagnosis of Post Traumatic Stress Disorder. Review on 2/25/25 of client #2's record revealed: -17 year old male. -Admitted on 1/10/25. -Diagnoses of Post Traumatic Stress Disorder and Major Depressive Disorder.	V 297		

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V 297	Continued From page 13 Review on 2/25/25 of client #3's record revealed: -13 year old male. -Admitted on 2/3/25. -Diagnoses of Major Depressive Disorder-Recurrent/Unspecified, Generalized Anxiety Disorder and Attention Deficit Hyperactivity Disorder- predominantly inattentive presentation. Review on 2/25/25 of staff #4's personnel record revealed: -Date of hire was 1/14/25. -She was hired as an Intern. Interview on 2/27/25 with client #1 revealed: -He only had a therapy session a few times. -He could not recall the dates. -Therapy was provided by the Intern and the Clinical Director. Interview on 2/27/25 with client #2 revealed: -He only had therapy once with staff #4 and once with the Clinical Director. -"I was told we are supposed to have therapy once a week, that's not happening." Interview on 2/2/7/25 with client #3 revealed: -He had therapy once or twice since his admission. -Stated therapy was provided by staff #4. Interview on 2/26/26 with staff #3 revealed: -She was informed the clients were to receive therapy sessions weekly. -She had not seen therapy services provided when she worked in the facility. Interview on 2/27/25 with the Intern revealed: -She was hired as an intern. -Currently working on her Masters in Counseling. -She worked 10am-3pm currently and would soon	V 297		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL076-063	A. BUILDING: _____ B. WING _____	R 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 297	Continued From page 14 change to work on second shift. -She provided the therapy sessions to the clients in the facility. -She had completed both individual therapy and group therapy with the clients. Interview on 3/5/25 with the Clinical Director revealed: -She completed the therapy sessions with the clients weekly. -Staff #4 worked 10am-3pm currently and would begin working during second shift. -When the Intern started, she stopped providing the therapy sessions to the clients. -She thought the Intern could provide therapy sessions. -Acknowledged the facility failed to ensure face to face clinical consultation was provided in the facility at least four hours a week by a Licensed Professional.	V 297		