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	MHL013-232	A. BUILDING: _____ B. WING _____	R 12/08/2025

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 12/8/25. The complaint was unsubstantiated (intake #NC00234404). 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 has a current census of 3. 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		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure treatment plans and strategies were developed to address the needs of the clients affecting 1 of 3 audited clients (Former Client (FC) #3) and failed to schedule a review of a plan at least annually affecting 1 of 3 audited clients (Client #2). The findings are:

Review on 12/4/25 of Client #2's record revealed:
-Admission date of 11/29/25.
-11 years old.
-Diagnoses of Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder.
-Individual Service Plan (ISP) dated 11/27/24.
-No evidence the ISP had been reviewed or updated annually.

Further review on 12/5/25 of Client #2's record revealed:
-Updated ISP dated 12/5/25.

Review on 12/5/25 of FC #3's record revealed:
-Admission date of 6/6/24.
-Discharge date of 10/7/25.
-13 years old.
-Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Autistic Disorder.
-ISP dated 6/19/25 had no goals or strategies to

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address elopement behaviors.

Review on 12/5/25 of the facility's incident reports from 9/1/25 to 10/7/25 revealed:
-FC #3 eloped from the facility 5 times with staff requiring police assistance for him to return.

Interview on 12/4/25 with Client #1 revealed:
-FC #3 frequently eloped from the facility.
-Staff were unable to stop FC #3 when he eloped.

Interview on 12/8/25 with FC #3 revealed:
-Admitted to eloping from the facility.
-Staff followed him when he eloped.
-Was unable to state the number of times or frequency of the elopement.

Interview on 12/8/25 with FC #3's legal guardian revealed:
-While living in the facility it was "common" for [FC #3] to elope.
-"In the summer, [FC #3] was running every day."
-Did not know if the facility had goals or strategies to address elopement behaviors.

Interview on 12/4/25 with Staff #1 revealed:
-FC #3's "only problem was running."
-FC #3's behavior would sometimes escalate "5 to 6 times in a day" resulting in elopement behavior.
-Was not sure if FC #3 had goals or strategies to address elopement behaviors.

Attempted interviews on 12/5/25 and 12/8/25 with Staff #2 and #3 were unsuccessful due to failure to return phone calls prior to survey exit.

Interview on 12/8/25 with Staff #5 revealed:
-FC #3 had "elopement issues."
-Did not know if FC #3 had goals or strategies to

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V 112	Continued From page 3 address elopement behaviors. -Had tried to set up a chart to address elopement behaviors, but "It didn't work." -FC #3 had been eloping "a lot" in recent months. Attempted interview on 12/8/25 with the Compliance Manager/Qualified Professional (QP) was unsuccessful due to her failure to return phone call prior to survey exit. Interview on 12/8/25 with the Licensee/Executive Director/Direct Support Professional revealed: -FC #3 eloped from the school as well as the facility. -FC #3 was eloping "3 or 4 times a day" prior to his discharge. -Talked to the treatment team about goals and strategies for elopement behavior, but goals were not developed due to FC #3's care manager changing. Interview on 12/8/25 with the Licensee/Administrative Director/QP revealed: -Was responsible for developing and updating treatment plans along with the Compliance Manager/QP. -Client #2's ISP should have been reviewed and updated prior to 11/27/25. -FC #3 had a history of elopement. -"Elopement was not a major issue (for FC #3) at first." -"Elopement was frequent with [FC #3]" -Had conversations with FC #3 about why he wanted to leave. -Staff tried to keep FC #3 in eyesight when he was on the porch and followed him if he left the facility. -Considered adding extra staff for FC #3. -Did not develop goals or strategies to address FC #3's elopement behaviors.	V 112		

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V 112	Continued From page 4 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
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 6 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 submit Level II incident reports to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are: Review on 12/5/25 of the facility's incident reports from 9/1/25 to 10/7/25 revealed: -FC #3 eloped from the facility on 10/2/25, 10/3/25, 10/4/25 and 10/7/25 requiring police intervention to return to the facility. Review on 12/5/25 of the facility's records revealed: -Incomplete information regarding FC #3's elopement incidents on 10/2/25 and 10/3/25 was entered into IRIS but was not submitted. Review on 10/20/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Level II incident reports were not submitted for FC #3's elopements requiring police involvement on 10/2/25, 10/3/25, 10/4/25 and 10/7/25.	V 367		

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V 367	Continued From page 7 Interview on 12/8/25 with the Licensee/Administrative Director/Qualified Professional (QP) revealed: -Acknowledged that level II incident reports were not submitted completely or at all within the required time frames. -All of the facility's QPs were responsible for completing level II incident reports. -Additional training was needed to ensure that all incident reports were submitted fully in IRIS within the required time frames. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		