

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL076-063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2026
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NAME OF PROVIDER OR SUPPLIER YOUTH UNLIMITED-SLANE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2872 YOUTH UNLIMITED DRIVE SOPHIA, NC 27350
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on March 30, 2026. The complaints were unsubstantiated (intake #NC00236191, NC00236361). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 2 current clients.</p> <p>A sister facility is identified in this report. The sister facility will be identified as Sister Facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.</p>	V 000		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p>	V 112		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 112	<p>Continued From page 1</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on interviews, observation and record review the facility failed to develop and implement goals and strategies to address the needs of one of two audited clients (Client #1). The findings are:</p> <p>Review on 3/4/26 of Client #1's record revealed: -Admission date of 10/9/25. -Diagnoses of Adjustment Disorder, Unspecified; Attention-Deficit Hyperactivity Disorder (ADHD), Unspecified Type. -15 years old -The Person-Centered Plan (PCP) dated 10/9/25 and last updated 2/16/26 had no goals or strategies to address self-injurious behavior. -He had a history of self-injurious behavior, suicidal ideation (SI) and suicide attempts which have caused disruption in his home and previous placements as identified in his discharge assessment, dated 10/3/26, from the crisis stabilization facility he transferred to this facility from.</p>	V 112		

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V 112	<p>Continued From page 2</p> <p>Review on 3/16/26 of Incident Response Improvement System (IRIS) reports from 10/1/25-3/16/26 revealed:</p> <p>3/16/26 incident: -"[Client #1] had a cord in his hand and made a statement, 'I am not going to be here the next day.' He verbally threatened staff throughout the night and the police were called and [Client #1] was transported to the local hospital Emergency Department (ED)."</p> <p>Review on 3/24/26 of local hospital ED records revealed: -Client #1 arrived at the ED on 3/16/26 after 1:00 am and received a Tele-Psych assessment at 3:00 am. -Client #1 denied SI/Homicidal Ideation (HI) or having a plan to harm himself. -Facility staff provided the hospital with a note from the Clinical Director reporting, "[Client #1] has been a danger to himself and others and had a cord in his hand earlier reporting that he 'would not be here tomorrow.' [Client #1] has had some manic behavior & acting out around the facility and there were concerns that he may cause harm to other residents. I am requesting [Client #1] be Involuntarily Committed (IVC'd) and evaluated by psychiatry." -Client #1 denied having had a cord or making any threats to kill himself or harm anyone else. -Client #1 admitted to saying, "If I don't show up at school tomorrow you won't care." -Client #1 reported the last time he threatened suicide was in "early January" 2026. -Client #1 was transferred to another local hospital facility on 3/18/26 for psychiatric care. -Client #1 was discharged from this local hospital back to the facility on 3/23/26.</p>	V 112		

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V 112	<p>Continued From page 3</p> <p>Interview and observation at 3:45 pm on 3/23/26 with Client #1 revealed:</p> <ul style="list-style-type: none"> - "Staff framed me for suicide" regarding the incident on 3/16/26. - He denied that he had tried to harm himself or had any SI that evening, "but staff took me to the hospital anyway." - He denied SI/HI or having a plan to harm himself. - He denied having had a cord or making any threats to kill himself or harm anyone else. - He acknowledged that he had cut his thigh, but that "it's in the past." - When asked when, why and with what he cut himself Client #1 shrugged his shoulders and said "I don't know." and "The past is in the past." - He had only told and shown one staff his cuts. - The cuts "were not deep" and bled "just a little." - The cuts required no first aid or medical attention, "I just washed them off." - This had been weeks ago, though he couldn't recall a date stating he thought it was in "early March" 2026. <p>Interview on 3/23/26 with Staff #1 revealed:</p> <ul style="list-style-type: none"> - On 3/16/26 between 5:00 pm and 6:00 pm Client #A1 and Client #A3 from Sister Facility A were walking with staff supervision near the facility. - Staff #A2 was following the female clients in a van. - Client #A1 and Client #A3 walked towards the facility while Client #1 and Client #2 were outside playing and Staff #1 came outside to redirect the male clients (Client #1 and Client #2) to not engage with the female clients (Client #A1 and Client #A3). - Staff #1 encouraged the 2 male clients (Client #1 and Client #2) to not engage with the female clients, one of whom (Client #A1) was trying to get Client #1's attention. 	V 112		

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V 112	<p>Continued From page 4</p> <ul style="list-style-type: none"> -The female clients (Client #A1 and Client #A3) walked on, but on the way back they tried to engage with Client #1 again -Client #1 began to speak to the female clients (Client #A1 and Client #A3). -Staff #A2 drove up in the van, and after redirection Client #A1 and Client #A3 got into the van. -Client #A1 kept the van door open while Client #1 was in the doorway of the van talking to her. -Staff from both facilities attempted to redirect Client #1 and Client #A1. -The other female (Client #A3) eventually started arguing with Client #1 to let them go back to their facility. -Client #1 made the statement "that if he wasn't there none of this would have happened." -Staff #1 took this to mean "that if he (Client #1) had accomplished suicide attempts prior to being placed in the facility the issues that have arisen here would not have occurred." -"After [Client #1] refused to get out of the van doorway, and argued with both staff, [Client #A1] got out of the van, and she and [Client #1] ran into the wooded area behind the facility." -Staff #A2 drove around in the van looking for Client #1 and Client #A1. -Staff #1 called the police as it was getting dark and the clients could not be seen. -"[Staff A2] found [Client #1 and Client #A1] near the end of the property (facility's back yard) by the woods with [Client #1] holding a cord and was threatening to choke himself with it." -"I called [House Director] and was on the phone with her when [Client #1 and Client #A1] returned to the front of the facility. I told [House Director] over the phone what the other staff told me about the cord and that [Client #1] may be trying to harm himself." -Staff #1 requested that the House Director come 	V 112		

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V 112	<p>Continued From page 5</p> <p>to the facility (she was not on campus working that night). -[Client #1] overheard her and began yelling and threatening me (Staff #1) while calling me names," as well as denying that he was trying to harm himself. -Police arrived and Client #1 denied threatening to harm himself and denied that he was having SI. -Police eventually left before the House Director arrived and after she arrived staff spoke to Client #1 about being evaluated at the hospital. -He agreed after some discussion and was taken to the local hospital ED by staff.</p> <p>Interview on 3/18/26 with Staff #A1 revealed: -Client #1 showed her multiple straight cuts he had made on the front of his left thigh. -They were not deep but had bled. -"They were not bleeding when he showed them to me." -She reported this to the House Director.</p> <p>Interview on 3/20/26 with House Director revealed: -She was aware that Client #1 has a history of self-injurious behavior and suicidal ideations. -She was aware of the incident with Client #1 threatening to harm himself on 3/16/26. -She was not working on campus that night but was called by staff who informed her of the incident. -She came to campus to help staff address the situation. -She was not aware of Client #1 having made cuts on his left thigh. This was never reported to her by staff or Client #1. -She was not aware of any other incidents of Client #1 making self-harming or suicidal statements beyond what led him to being</p>	V 112		

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V 112	<p>Continued From page 6</p> <p>hospitalized on 3/16/26.</p> <p>-Client #1 did not have any goals or strategies to address self-harm and SI.</p> <p>Interview on 3/11/26, 3/23/26 and 3/30/26 with the Clinical Director revealed:</p> <p>-[Client #1] tends to say that he will 'just kill himself' when he gets in trouble. It's his go to."</p> <p>-She is responsible for writing and updating the clients' PCPs.</p> <p>-She was aware Client #1 had a history of self-injurious behavior as she had asked him about it in Client #1's interview prior to admission.</p> <p>-The issue of self-injurious behavior had been discussed in supervisory meetings with the Executive Director and the House Directors.</p> <p>-"It didn't occur to me to add any specific goals or strategies to [Client #1's] PCP to address self-injurious behavior."</p> <p>-She stated there had been goals regarding self-injurious behavior but they were "pretty general."</p> <p>-She acknowledged that Client #1's PCP had no goals or strategies to address his self-injurious behavior.</p> <p>Review on 3/30/26 of the Plan of Protection dated 3/30/26 written by the Clinical Director revealed:</p> <p>"What immediate action will the facility take to ensure the safety of the consumers in your care? The PCP was reviewed and revised to specifically address risk of self-harming behaviors, including measurable goals, individualized interventions, supervision guidelines, and crisis planning. Staff will be informed of updates and interventions will be implemented immediately. An example is:</p> <p>Goal: The adolescent will demonstrate improved</p>	V 112		

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V 112	<p>Continued From page 7</p> <p>emotional regulation, problem-solving, and safety awareness as evidenced by a reduction in self-harming behaviors from baseline to zero incidents over a consecutive 90-day period.</p> <p>Measurable Objectives:</p> <p>Identify Triggers The adolescent will identify and verbally report at least 3 personal triggers (e.g., conflict, anxiety, feeling unsafe) that lead to urges to self-harm in 4 out of 5 sessions, as measured by therapist documentation.</p> <p>Develop Coping Skills The adolescent will demonstrate use of at least 3 coping strategies (e.g., deep breathing, seeking staff support, grounding techniques) when experiencing distress in 80% of observed opportunities, as documented by staff or caregiver reports.</p> <p>Increase Help-Seeking Behavior The adolescent will appropriately seek support from a trusted adult before self-harming in 4 out of 5 opportunities, as reported by caregivers/staff.</p> <p>Safety Planning The adolescent will collaborate in creating and following an individualized safety plan (including safe alternatives to leaving) and will review/update the plan monthly with the therapist.</p> <p>Reduce Incidents The frequency of self-harming incidents will decrease by 50% within 60 days and reach zero incidents for 90 consecutive days, as tracked through incident reports.</p> <p>Interventions (Evidence-Based): Cognitive Behavioral Therapy (CBT): To help the adolescent recognize thoughts/feelings that precede self-harming behaviors and replace them with safer alternatives.</p> <p>Trauma-Informed Care (ARC (Attachment, Regulation and Competency) Model):</p>	V 112		

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V 112	<p>Continued From page 8</p> <p>Focus on attachment, self-regulation, and competency to address underlying trauma driving self-harming behaviors.</p> <p>Describe your plans to make sure the above happens.</p> <p>Staff will be informed of updates and interventions will be implemented immediately.</p> <p>The Clinical Director will complete monthly audits to ensure the risks of self-harming behaviors are addressed and plans are updated timely.</p> <p>Findings will be reviewed in QA/QI (Quality Assurance/Quality Improvement) meetings.</p> <p>Summary Statement:</p> <p>While the original treatment plan was appropriately approved by the Medical Director and MCO (Manage Care Organization) the facility has strengthened its treatment planning process to ensure greater specificity, individualization, and responsiveness to elopement behaviors. Ongoing monitoring and training will ensure sustained compliance with 10A NCAC 27G .0205 (c-d)."</p> <p>Client #1 was a 15 year old male and had diagnoses of Adjustment disorder, Unspecified; Attention-Deficit Hyperactivity Disorder (ADHD), Unspecified Type. Client #1 had a history of self-injurious behavior, suicidal ideation (SI) and suicide attempts which caused disruption at home and in previous placements. On 3/16/26 Client #1 was upset and involved in an argument with a female client from Sister Facility A. Client #1 and the client from Sister Facility A eloped off from the facility together. Facility staff called the local police as well as drove around searching for the clients. Client #1 and the client from Sister Facility A returned to the facility and Client #1 was holding a cord and was threatening to choke himself. Client #1 became upset when he heard facility staff reporting to the House Manager about Client #1 threatening to harm himself.</p>	V 112		
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V 112	<p>Continued From page 9</p> <p>Client #1 then threatened and yelled at facility staff. Client #1 was taken to a local hospital to be evaluated and was later transferred and admitted to another local hospital for further evaluation and was discharged on 3/23/26. There was an incident of an unknown date that Client #1 showed facility staff multiple cuts he had made on the front of his left thigh. Client #1 also admitted during his hospital visit of making suicidal threats in January 2026. The facility did not have goals or strategies for Client #1 to address his self-injurious behavior and suicidal ideation.</p> <p>This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.</p>	V 112		