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V 000	INITIAL COMMENTS An annual and complaint survey was completed on March 30, 2026. The complaints were substantiated (NC00236359, NC00236363, NC00236366). 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 4 and has a current census of 4. The survey sample consisted of audits of 4 clients. This facility is located on a large campus with three sister facilities. The sister facilities will be identified as A, B and C. Two sister facilities are identified in this report. The sister facilities will be identified as Sister Facility A and Sister Facility B. Sister Facility staff and clients will be identified using the letter of the facility and a numerical identifier.	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;	V 112		

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V 112	Continued From page 1 (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. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to develop and implement goals and strategies to address the needs of one of four clients (Client #1). The findings are: Review on 3/5/26 of Client #1's record revealed: -Admission date of 10/23/25. -Diagnoses of Post-Traumatic Stress Disorder (PTSD), Unspecified; Oppositional Defiant Disorder (ODD); Adjustment Disorder, Unspecified; Disruptive Mood Dysregulation Disorder (DMDD). -15 years old -Assessment dated 9/17/25: -Client #1 had a history of elopement from previous placements. -Elopement was identified as one of the reasons for her being discharged from her previous Level	V 112		

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3 facility on 8/8/25.
-She had an incident on 2/20/26 where she eloped and met Client #A1 and walked around the facility campus.
-She also had an incident of elopement on 2/22/26 in which she went to Sister Facility A and was arguing with staff as well as being verbally and physically aggressive.
-She was hospitalized after the 2/22/26 incident and was returned to the facility following discharge from the hospital on 2/29/26.
-Person-Centered Plan (PCP) dated 10/19/25 and last updated 2/26/26 had no goals or strategies to address elopement.

Review on 3/16/26 of Incident Response Improvement System (IRIS) reports from 10/1/25-3/16/26 revealed:
Client #1 eloped from the facility on the following dates:

-2/11/26 incident:
-"Client (Client #1) walked off with another peer and refused to follow staff prompts to return. Client eventually returned, but then got upset with staff and walked off again. Staff followed client until she went through the woods and staff lost sight. Staff called authorities (local County Sheriff's Department). Client was returned around 2:30 am."

-2/20/26 incident:
-"Client (Client #1) fled from her room out of her window. Staff looked for client on the property and then called authorities (local County Sheriff's Department) when unable to locate. Client was returned to the home (facility) after being found on the property."

-2/22/26 incident:

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-"Client (Client #1) was upset about thinking staff had said something that was not true (being in an area she was not supposed to be, to other staff) about her. She walked to the house (Sister Facility A) the staff was working and began verbally threatening the staff and banging on the windows for the staff to come out. She eventually returned to the house (facility) and continued threats to leave the facility again. She volunteered to go to the hospital for an assessment where she remains."

Review on 3/17/26 of local County Sheriff's Department report dated 2/12/26:
-Deputy arrived at approximately 7:55 PM on 2/11/26 to the facility's campus.
-Law Enforcement Officer (LEO) spoke with Sister Facility A staff.
-LEO was informed regarding the incident with Client #1, Client #2 and Client #A1 all having been Absent Without Leave (AWOL) from their facilities and moving around the campus.
- Client #A1 had reportedly threatened suicide and Client #1 was "checking on him" according to Staff #A1.
-LEO spoke with Staff #1 and Staff #2 from the facility regarding Client #1's and Client #2's behaviors, and descriptions.
-Searches were conducted in the woods on the facility campus as well as in areas off the facility campus where Client #A1 had been located previously.
-Both drones and K9 Units were deployed to aid in the search for Client #1, Client #2 and Client #A1.
- Client #1, Client #2 and Client #A1 were last reportedly seen at an address near the facility's campus at approximately 9:37 PM.
-At approximately 2:15 AM Client #1, Client #2 and Client #A1 were located at a different

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address, reportedly under construction, near the one where they were last spotted.
- Client #1, Client #2 and Client #A1 were confirmed to be the missing juveniles, denied needing medical treatment from Emergency Medical Services (EMS), denied intent to harm themselves, were taken into custody and returned to their respective facilities at approximately 2:30 AM.

Observation at 2:15 pm on 3/16/26 of the facility campus revealed:
-The facility is 0.3 miles from Sister Facility A.

Interview on 3/5/26 with Client #1 revealed:
-On 2/11/26 "some of the boys (Client A1 and Client A2) got upset and came down to this house (facility). The girls left the facility and started chasing after the boys. The Middle Schoolers (Client #2 and Client #A2) were chasing each other and me (Client #1) and [Client #3] were chasing after [Client #A1]. I (Client #1) kept chasing after [Client #A1] in order to calm him down." He had been upset and made a statement of Suicidal Ideation (SI). "[Client #2] caught up to us, and [Client #A1] and [Client #2] talked about running away. We kept walking and by the time [Client #A1] had calmed down we had already walked off campus. I (Client #1) figured I was going to get in trouble anyway so I just followed [Client #A1] and [Client #2.] We walked for about 2 hours when we found a house with the door open. We went in there and stayed in the house for a couple hours."
-When asked what happened in the house in the intervening hours between them entering it and the police finding them Client #1 stated that she and Client #A1 "got intimate" during the time in the house.
-"The situation had not been planned, it just

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happened. One thing led to another and it just kept escalating."

Interview on 3/5/26 with Client #2 revealed:
In regard to the elopement on 2/11/26,
-"Not much really happened."
-The situation began when she (Client #2) left the facility to go for a walk down the dirt road. They are allowed to walk as a coping skill with staff permission, but she did not get permission before leaving the facilty this time.
-"I went back to the house (facility) on my own. About 5 minutes after I got back (to the facility) [Client #3] left to talk to [Client #A1] and [Client #1] followed her (out of the facility)."
-"I waited a few minutes, then tried to go after [Client #3] and [Client #1] but staff told me no. I went to my room and jumped out the window to go stop them (the other clients) from doing something they would regret."
-"[Client #A1] said staff were probably already calling the police and [Client #1] told me to 'come on' and we walked into the woods. It got dark, we were tired and [Client #A1] said 'there's a workshop, maybe it's open.'
[Client A1] tried the door, went in and we followed him."
-She stated that she doesn't remember the intervening hours until the police showed up. She and Client #1 decided to turn themselves in.
-When asked about the time between going into the house and the police showing up she reported that she remembers she fell asleep on the floor.
-She did not recall Client #A1 and Client #1 having any inappropriate contact.
-She stated she doesn't remember anything else.
-"It was not planned, it just happened."

Interview on 3/4/26 with Client #A1 revealed:

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V 112	Continued From page 6 -Regarding the incident on 2/11/26: Client #A1, Client #1 and Client #2 walked off from their facilities and were running through the woods. -"I ran out of the house (Sister Facility A) and ran up to the girls' facility and they (Client #1 and Client #2) ran towards him. I cut into the woods to avoid staff and the 2 girls followed me." -While walking around they felt tired and went into an unlocked shed of a house that was under renovation. -"I remember coming out of the shed and putting my hands up for the police" -He acknowledged that he did have sex with Client #1. -It had not been planned. "I just left the house and the girls followed me and we wandered until we found the house being renovated." - He reported that during this situation the opportunity just presented itself for he and Client #1 to have sex, and they took the opportunity. Interview on 3/5/26 and 3/16/26 with Staff #1 revealed: -Regarding the incident on 2/11/26: "Before 6:00 pm [Client #2] became upset after being asked to clean her bedroom and left the facility around 5:45 pm without staff permission or supervision." -[Client #2] had "jumped out of her window." -Facility staff followed their protocol when clients go AWOL from any of the agency's facilities, putting all of their facilities on lockdown. The facility staff called for a facility lockdown. -"[Client #1] had also 'jumped out of her bedroom window.'" "[Client #1] and [Client #2] met up with [Client #A1] and ran off campus together." -She followed the clients driving around campus in a vehicle looking for the clients.	V 112		

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V 112	Continued From page 7 -The Local County Sheriff's Department was called. The clients were located by police in an abandoned house and were brought back to their facilities around 2:30 am. -The protocol is to wait 30 minutes after the clients are off campus to call the police, but they can't always tell if the clients have gone off campus. -[Client #1 and Client #A1] have both gone AWOL from their facilities multiple times since this incident but nothing like this has happened again. -They have been opening Client #1's door more often to check on her since this incident. Interview on 3/4/26 and 3/17/26 with Staff #A1 revealed: -The day of 2/11/26 "was a normal day until the end of room time." -"We received a call that [Client #2], who [Client #A2] was 'involved with (relationship),' had left the house (facility) and staff called for a lockdown." -"[Client #A1 and Client #A2] met up with [Client #2], [Staff #1] found her and picked up [Client #2] and took her back to the house (facility)." -[Client #1] and [Client #2] had eloped from the facility again. [Client #A2] was upset and left his facility again. -Client #1, Client #2 and Client #A1 met up and had been out of staff eyesight in the woods for approximately 30 minutes. -Per licensee protocol the Local County Sheriff's Department were called after 30 minutes of clients being out of staff's eyesight. -Throughout the time period from when the incident started staff from both homes were out looking for clients and encouraging them to go back to their facility when found as well as "keeping eyes on them the best we could." -"The following and looking for clients lasted more than 2 hours." Local County Sheriff Deputies	V 112		

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V 112	Continued From page 8 arrived at [Sister Facility A] and were informed of the situation. Police went back and forth between [Sister Facility A] and the search area looking for the clients. She got a call around 2:30 am that the Clients were found and were back at the facility. -The clients were found "in a house under construction" in a nearby neighborhood. Interview on 3/4/26 and 3/17/26 with Sister Facility A House Director revealed: -On 2/11/26 the House Director and Staff #3 were on shift. -The clients involved in the 2/11/26 incident were Client #1, Client #2, Client #3, Client #A1 and Client #A2. -Client #A1 eloped from their the facility around 4:30 pm-5:00 pm. -A lockdown was called because Client #1 and Client #2 had eloped from the facility and were out walking around campus. -"[Client #A1 and Client #A2] left the house (Sister Facility A) during the lockdown to go see what was going on." -Client #A1 and Client #A2 met up Client #1 and Client #3 on the road between the facilities. -"For 2 hours or so the clients from both facilities were running around campus and going into the woods while ignoring staff redirections to return." -Client #3 and Client #A2 was eventually brought back to their facilities. Client #1, Client #2 and Client #A1 remained in the woods and were out of staff's eyesight. -"The Clients were out of staff's eyesight for about 30 minutes. I called the police per (facility) protocol at 7:50 pm." -Client #1, Client #2 and Client #A1 left the facility's campus and traveled to a nearby neighborhood. and were hiding in a vacant house that was under construction.	V 112		

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V 112	Continued From page 9 -Client #1 and Client #A1 admitted to having sex while hiding in the vacant house. -The Local County Sheriff's Department found the clients and brought them back to their facilities late that night. Interview on 3/5/26 with House Director of this facility revealed: -He was not working the night of 2/11/26 when the incident occurred, but he was kept updated about it. -"Two of the girls (Client #1 and Client #2) went to the boys' house (Sister Facility A), walking off without permission. They were not listening to staff prompts. The clients left campus, the two girls and one boy (from Sister Facility A)." -"Staff couldn't keep up with them. Staff followed protocol and called the authorities (local County Sheriff's Department). [Local] County sheriff's Department Deputies came out to look for the clients." -The clients were found around 2:30 am. He thought the clients were in a vacant home near the facility campus, -He was informed that Client #1 and Client #A1 had sex. -They got a Plan B pill for Client #1 and she refused to take it. -Client #1 was taken to the doctor to get tested for pregnancy and sexually transmitted diseases (STDs) with the results all being negative. -Since this incident there has been a lot of processing with the clients, and "reminding staff to try to convince clients to not go AWOL." -Client #1 went to the hospital 2/22/26 for a similar incident. -They have been "keeping a closer eye on the kids (Clients)." -They did not change any policies, but they have increased their awareness of clients' behaviors,	V 112		

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as well as check in on them more often than previously (every 15 minutes instead of every 30 minutes).

Interview on 3/16/26, 3/23/26 and 3/30/26 with the Clinical Director revealed:
-She is responsible for writing and updating clients' PCPs.
-She was aware Client #1 had a history of elopement.
-The issue of elopement had been discussed in supervisory meetings with the Executive Director and the House Directors.
-She "had not thought" to add any specific goals or strategies to Client #1's PCP to address elopement.
-She acknowledged that Client #1's PCP had no goals or strategies to address her elopement.

Review on 3/30/26 of the Plan of Protection dated 3/30/26 written by the Clinical Director revealed:
"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 elopement risk, 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:

Goal:
The adolescent will demonstrate improved emotional regulation, problem-solving, and safety awareness as evidenced by a reduction in elopement behaviors from baseline to zero incidents over a consecutive 90-day period.
Measurable Objectives:
Identify Triggers
The adolescent will identify and verbally report at least 3 personal triggers (e.g., conflict, anxiety,

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feeling unsafe) that lead to urges to elope in 4 out of 5 sessions, as measured by therapist documentation.
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.
Increase Help-Seeking Behavior
The adolescent will appropriately seek support from a trusted adult before leaving a safe environment in 4 out of 5 opportunities, as reported by caregivers/staff.
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.
Reduce Incidents
The frequency of elopement incidents will decrease by 50% within 60 days and reach zero incidents for 90 consecutive days, as tracked through incident reports.
Interventions (Evidence-Based):
Cognitive Behavioral Therapy (CBT):
To help the adolescent recognize thoughts/feelings that precede elopement and replace them with safer alternatives.
Trauma-Informed Care (ARC (Attachment, Regulation and Competency) Model):
Focus on attachment, self-regulation, and competency to address underlying trauma driving flight behaviors.
Behavioral Reinforcement:
Implement a structured reward system for remaining in safe environments and using coping skills.
Skill Building:

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Family/Caregiver/staff Involvement:
Train caregivers/staff in consistent responses, supervision, and reinforcing positive behaviors. Describe your plans to make sure the above happens.
Staff will be informed of updates and interventions will be implemented immediately. The Clinical Director will complete monthly audits to ensure elopement risks are addressed and plans are updated timely. Findings will be reviewed in Quality Assurance/Quality Improvement (QA/QI) meetings.
Summary Statement:
While the original treatment plan was appropriately approved by the Medical Director and MCO and staff followed established elopement policies, 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).

Client #1 was a 15 year old female and had diagnoses of PTSD, Unspecified; ODD; Adjustment Disorder, Unspecified; DMDD. Client #1 had a history of which caused disruption at previous placements. Client #1 had incidents of elopement from the facility on 2/11/26, 2/20/26 and 2/22/26. During the 2/11/26 incident Client #1 eloped from the facility with clients from the facility and male clients from Sister Facility A. The facility staff searched for the clients and reported the missing clients to the local police department who assisted in the search for the missing clients deploying drones and search dogs. The local police found Client #1 and the other clients hiding at an address near the facility campus around 2:30 am. It was discovered that during the elopement Client #1 engaged in sexual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL076-068	A. BUILDING: _____ B. WING _____	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUTH UNLIMITED HAYWORTH HOME	2748 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 112	Continued From page 13 intercourse with the male client who eloped with her. During the 2/22/26 incident Client #1 eloped from her facility and had traveled down to Sister Facility A and was upset and verbally aggressive towards the staff there. After this incident she was taken to a local hospital to be evaluated. The facility did not develop and implement goals or strategies to address Client #1's elopement behavior. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 112		