

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF HEALTH SERVICE REGULATION



ROY COOPER  
GOVERNOR

MANDY COHEN, MD, MPH  
SECRETARY

MARK PAYNE  
DIRECTOR

March 22, 2018

Jean C. Majors  
Helping Hands Group Home, LLC  
P.O. Box 842  
Graham, NC 27253

Re: Complaint Survey completed March 20, 2018  
Helping Hands Group Home, LLC, 322/324 Walker Avenue, Graham, NC 27253  
MHL #: 001-192  
E-mail Address: jmajors59@bellsouth.net  
Intake #: NC00136677

Dear Ms. Jean Majors:

Thank you for the cooperation and courtesy extended during the Complaint Survey completed March 20, 2018. The complaint was unsubstantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is May 19, 2018.

What to include in the Plan of Correction

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. **Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.**

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

WWW.NCDHHS.GOV  
TEL 919-853-3795 • FAX 919-715-8078  
LOCATION: 1800 UMSTEAD DRIVE • WILLIAMS BUILDING • RALEIGH, NC 27603  
MAILING ADDRESS: 2718 MAIL SERVICE CENTER • RALEIGH, NC 27699-2718  
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section  
NC Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown, Team Leader at 919-855-3822.

Sincerely,



Edgar Garrido, MSW  
Facility Survey Consultant I  
Mental Health Licensure & Certification Section



Kimberly R Sauts  
Facility Survey Consultant I  
Mental Health Licensure & Certification Section  
Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO  
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO  
Trey Suttan, Interim Director, Cardinal Innovations LME/MCO  
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO  
Victoria Whitt, Director, Sandhills Center LME/MCO  
Carol Robertson, Quality Management Director, Sandhills Center LME/MCO  
File

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>MHL001-192</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED <b>03/20/2018</b> C
NAME OF PROVIDER OR SUPPLIER <b>HELPING HANDS GROUP HOME, LLC</b>				
STREET ADDRESS, CITY, STATE, ZIP CODE <b>322/324 WALKER AVENUE GRAHAM, NC 27253</b>				

(X4) ID PREFIX TAG V 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG V 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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INITIAL COMMENTS	27G, 5602 Supervised Living - Staff	10A NCAC 27G .5602 STAFF	(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.	(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.	(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:	(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or	(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients
V 000	A complaint survey was completed on March 20, 2018. The complaint was unsubstantiated (intake #NC00136677). Deficiencies were cited.	The facility is licensed for the following service category: 10A NCAC 27 G .5600A Supervised Living for Adults with Mental Illness.					

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(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	STREET ADDRESS, CITY, STATE, ZIP CODE <b>322/324 WALKER AVENUE GRAHAM, NC 27253</b>			
(X3) DATE SURVEY COMPLETED <b>C</b> <b>03/20/2018</b>				

(X4) ID PREFIX TAG <b>V 290</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG <b>V 290</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
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Continued From page 1			
<p>present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assess a client's capability of having unsupervised time in the community without staff supervision affecting one of three audited clients (#1). The findings are: Review on 3/20/18 of client #1's record revealed: Admission date of 12/1/17. -Diagnoses of Schizoaffective Disorder, Developmental Disorder with Chronic Intellectual Impairment-Mild, Diabetes, Hypertension, Hypercholesterolemia and Hypothyroidism. -There was no documentation that client #1 had been assessed for capability of having unsupervised time in the community without staff supervision. Interview with client #1 on 3/20/18 revealed: -She did have unsupervised time in February 2018.</p>			
<p>Staff, Director and Q/P will review client's PCP whenever there is a request for time in the community (Such as attending Church) to assure that an assessment for time without staff's presence has been completed, and signed by the appropriate individuals.</p>			

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  <b>HELPING HANDS GROUP HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>322/324 WALKER AVENUE GRAHAM, NC 27253</b>
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V 290	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>-She wanted to go to church with a male friend.</li> <li>-The Licensee dropped her off to her male friend's church.</li> <li>-She thought they were at church together for over an hour.</li> <li>-There was no group home staff with her at the male friend's church.</li> <li>-After church she went to the male friend's house.</li> <li>-She was not sure how long she was at the friend's house.</li> </ul> <p>Interview with staff #1 on 3/20/18 revealed:</p> <ul style="list-style-type: none"> <li>-Client #1 was allowed to have unsupervised time in the community.</li> <li>-Client #1 was allowed to use unsupervised time in the community to be with a male friend.</li> <li>-Client #1 went to church with this male friend unsupervised by staff.</li> <li>-She could not specify how often client #1 used unsupervised time in the community.</li> <li>-She confirmed the facility failed to assess client #1's capability of having unsupervised time in the community.</li> </ul> <p>Interview with the Licensee on 3/20/18 revealed:</p> <ul style="list-style-type: none"> <li>-She allowed client #1 to have unsupervised time in the community with a male friend.</li> <li>-She dropped client #1 off to the male friend's church about two months ago.</li> <li>-Client #1 kept asking her if she could attend church with this male friend.</li> <li>-She did not realize this was an issue because client #1 was with a friend.</li> <li>-She confirmed the facility failed to assess client #1's capability of having unsupervised time in the community.</li> </ul>	V 290		