STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING ______ B. WING ______	C 05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	**1317 HELMSDALE DR** **CARY, NC 27511**

(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) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was conducted on May 11, 2018 of allegation NC00138713 and NC00138715. The allegations were not substantiated. However, a condition of participation in client protections was cited while conducting this survey.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to: implement policies intended to prohibit possible neglect of clients (W149) and thoroughly investigate allegations of neglect that affected 1 of 1 audit clients (#1) in the home (W154). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement policies intended to prohibit neglect of clients. This affected 1 of 1	W 149		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 audit clients in the home (#1). The finding is: Facility Management neglected to implement policies intended to prevent neglect of clients in the home. Management failed to thoroughly investigate an allegation of client #1 leaving the facility through his bedroom window and going to a neighbor's home. Review on 5/11/18 of an alleged incident of an elopement onto the roof by client #1 was revealed to be currently under investigation. During this review, raw data for the past six months revealed no other incidents of elopement. However, review of the incident log revealed an incident reported on 5/2/18 noting that client #1 ran out of the front door and rang a neighbor's door bell. No other documentation of this incident was located. Interview with the operations manager on 5/11/18 revealed no investigation of the incident and she stated she was never made aware of an incident of client #1 leaving the facility. Additional interview 5/11/18 with three (3) direct care staff revealed client #1 had left the house via his window and had been brought back by a neighbor. All three staff stated this occurred on 5/2/18 which is approximately one week prior to the roof incident. The staff (all three) also revealed the previous shift admitted they turned off the alarm to client #1's bedroom window prior to him eloping on 5/2/18. Furthermore, all three of the staff interviewed stated that the operations manager and the qualified intellectual disability professional (QIDP) were made aware of the incident.	W 149		

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W 149	Continued From page 2 Interview on 5/11/18 with the QIDP revealed the elopement mentioned on 5/2/18 was an incident that had been reported to him by staff as soon as the neighbor returned client #1 on 5/2/18. After that he stated, that the alarm on the client #1's window had been turned off by the shift prior to the elopement because it was constantly going off for no reason. He indicated he immediately corrected the staff verbally and notified the operations manager and home manager. He stated the home manager was to formally discipline the staff and hold a staff meeting but he did not think she had done these things by the next week when the new elopement occurred. At this time, the investigating team of the new elopement incident immediately suspended the home manager and two staff. He further revealed the operations manager makes the decision on rather to investigate incidents or not and that he did not know if this first incident of elopement had been investigated. Interview with the operations manager on 5/11/18 revealed she was notified of issues with the window alarm but that nobody had told her client #1 had left the facility and been returned by a neighbor on 5/2/18. She informed staff to immediately do a one time check of all window alarms and notify her immediately if one was not working. She stated if something like an elopement happened she would tell her supervisor (the Executive Director) and he would make the decision on investigating or not. Interview on 5/11/18 with the the executive director on 5/11/18 revealed he was not aware of the elopement out of the window when client #1 was returned by the neighbors on 5/2/18 and that	W 149		

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W 149	Continued From page 3	W 149		

if he would have been aware, this type of incident would have definitely been investigated thoroughly.

Review on 5/11/18 of client #1's record revealed an individual program plan (IPP) dated 2/5/18. Further review of his record revealed he is verbal and has diagnoses of mild intellectual disability, autism, Asperger's Syndrome, ADHD, ODD, depression, generalized anxiety, and fetal alcohol syndrome. The IPP indicated client #1 was a minor and that at his current age of 15 years old, his parents serve as his legal guardian of the person. Additional review of his IPP revealed he communicates his wants and needs and he has a non-negotiable preference of being able to walk around the home freely.

Review on 5/11/18 of client #1's record revealed a behavior support plan (BSP) dated 5/22/17. This plan addressed noncompliance, physical aggression and property destruction. Further review of his record revealed he was admitted on 1/2/17 and that prior to admission the admission, there was a cross-systems crisis prevention and intervention plan developed 6/21/16. This plan included interventions for yelling, avoiding chores, saying no or ignoring requests. It also addressed the behaviors of cursing, escalated kicking and hitting, biting himself, head banging, attempts to use objects to hurt others, property destruction. The plan also addressed his ADHD/impulsivity but there were no noted behaviors of elopement. According to the record, there was no history of elopement.

The facility failed to thoroughly investigate one allegation of client #1 eloping out of his bedroom window and being returned by the neighbor

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W 149	Continued From page 4 before he was noticed missing by staff. The facility neglected to thoroughly investigate the direct care staff who turned off the alarm to client #1's bedroom window earlier the same day of the incident of elopement. The system of reporting to management incidents of possible neglect failed. There was also a failure of management staff at the facility to detect, identify, investigate the allegation and follow their own facility policy reporting and investigating possible neglect and this resulted in their systemic failure to ensure statutorily mandated services of client protections.	W 149		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct a thorough investigation of an allegation for 1 of 1 audit clients (#1) who allegedly eloped from the home. The finding is: Management failed to thoroughly investigate an allegation of client #1 leaving the facility through his bedroom window and going to a neighbor's home. Review on 5/11/18 of an alleged incident of an elopement onto the roof on 5/8/18 by client #1 was revealed to be currently under investigation. During this review, raw data for the past six months revealed no other incidents of elopement. However, review of the incident log revealed an incident reported on 5/2/18 noting that client #1	W 154		

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W 154	Continued From page 5	W 154		

ran out of the front door and rang a neighbor's door bell. No other documentation of this incident was located.

Interview with the operations manager on 5/11/18 revealed no investigation of the incident and she stated she was never made aware of an incident of client #1 leaving the facility.

Additional interview 5/11/18 with three (3) direct care staff revealed client #1 had left the house via his window and had been brought back by a neighbor on 5/2/18. All three staff stated this occurred on 5/2/18 which is approximately one week prior to the roof incident. The staff (all three) also revealed the previous shift admitted that earlier that day, they turned off the alarm to his bedroom window and all three of the staff stated that the operations manager and the qualified intellectual disability professional (QIDP) were aware of the incident of elopement.

Interview on 5/11/18 with the QIDP revealed the elopement mentioned on 5/2/18 was an incident that had been reported to him by staff as soon as the neighbor returned client #1 on 5/2/18. The QIDP also indicated that he discovered, after the elopement, that the alarm on client #1's bedroom window had been turned off by the shift prior to the elopement because it was constantly going off for no reason. He indicated that he immediately corrected the staff verbally and notified the operations manager and the home manager. He further indicated the home manager was to formally discipline the staff and hold a staff meeting;however, he did not think she had done these things by the next week when the new elopement occurred. After the 5/8/18 the internal investigative team began their

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W 154	Continued From page 6	W 154		

inquiry into the roof elopement incident they immediately suspended the home manager and two direct care staff. The QIDP further revealed the operations manager typically makes the decision on whether to investigate incidents or not. The QIDP that he did not know for sure if this first incident of elopement on 5/2/18 had been investigated.

Interview with the operations manager on 5/11/18 revealed she was notified of issues with the window alarm but that nobody had told her client #1 had left the facility and been returned by a neighbor on 5/2/18 even before staff noticed he was missing. She informed staff on duty to do a one time check of all window alarms and notify her immediately if one was not working. She stated if something like an elopement had happened and she was told, she would inform her supervisor (the executive director) and he would make the decision of investigating or not investigating.

Interview with the executive director, on 5/11/18, revealed he was not aware of the alleged elopement on 5/2/18 out of the bedroom window. He was not aware that client #1 was returned by the neighbors on 5/2/18 even before staff noticed him missing. He further revealed that if he would have been aware, this type of incident would have definitely been thoroughly investigated.

Review on 5/11/18 of client #1's record revealed an individual program plan (IPP) dated 2/5/18. Further review of his record revealed he is verbal and has diagnoses of mild intellectual disabilities, autism, Asperger's Syndrome, ADHD, ODD, depression, generalized anxiety, ASD and fetal alcohol syndrome. The IPP indicated client #1

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W 154	Continued From page 7 was a minor and at his age of 15, his parents serve as his guardian of the person. Additional review of his IPP on 5/11/18 revealed he communicates his wants and needs and he has a non-negotiable of being able to walk around the home freely. Review on 5/11/18 of client #1's record revealed a behavior support plan (BSP) dated 5/22/17. This plan addressed noncompliance, physical aggression and property destruction. Further review of his record revealed he was admitted on 1/2/17 and that prior to admission the admission, there was a cross-systems crisis prevention and intervention plan developed 6/21/16. This plan included interventions for yelling, avoiding chores, saying no or ignoring requests. It also addressed the behaviors of cursing, escalated kicking and hitting, biting himself, head banging, attempts to use objects to hurt others, property destruction. The plan also addressed his ADHD/impulsivity but there were no noted behaviors of elopement. According to the record there was no history of elopement. The facility failed to thoroughly investigate one allegation of client #1 eloping out of the window and subsequently being returned by the neighbor before he was noticed missing by the staff. The facility neglected to thoroughly investigate the direct care staff who turned off the alarm to client #1's bedroom window. The system of reporting to management incidents of possible neglect failed. Furthermore, the failure of management staff at the facility to detect, identify, investigate these allegations and follow their own facility policy reporting and investigating possible neglect resulted in their systemic failure to ensure statutorily mandated services of client protections	W 154		

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W 154	Continued From page 8 to the clients residing in the facility.	W 154		