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 _____	07/18/2018

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HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

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E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.	E 036	The noted deficiency will be corrected by the following actions: A. Helmsdale Management team will review the Emergency Preparedness Plan (EPP) to ensure that the plan contains all information as required. If needed, Qualified Professional and Program Manager will revise plan where needed. B. As part of their initial On-The-Job Training,all staff will be trained on the EPP within 2 weeks of physically entering their work site. All training of the EPP will be documented on Rescare's OTJ Checklist, and include testing to verify successful completion. C. Helmsdale Management Team will develop a monthly schedule to include EPP drills. All staff will participate in drills on a monthly basis to ensure that they are prepared to execute the EPP should any emergencies arise. These drills will be documented on our standard Disaster Drill Form. D. The Residential Manager (RM) and/or Clinical Supervisor will monitor 3x/ weekly to ensure that trainings have been completed as outlined and that drills are occuring as scheduled. Program Manager (PM) will review the above information weekly. DHSR - Mental Health AUG 13 2018 Lic. & Cert. Section	9/1/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Program Manager | (X6) DATE: 8/6/18

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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E 036	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that all staff working in the facility were trained and tested on the emergency preparedness program (EPP). The finding is: The facility did not ensure all staff working in the facility had been tested on their emergency preparedness program. During observations in the facility on 7/17/18 two direct care staff were interviewed on the facility's emergency preparedness program. Both staff indicated they were newly employed at the facility and had not yet received training on the EPP. Record review on 7/17/18 revealed a training for emergency preparedness provided by the qualified intellectual disabilities professional (QIDP) that included several staff that worked in the facility. However, the two direct care staff working in the facility on 7/17/18 and on 7/18/18 were not on the training inservice. Interview on 7/18/18 with the QIDP confirmed both direct care staff interviewed were newly employed at the facility and neither had been tested on the facility's EPP.	E 036	See page 1	
W 102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met.	W 102	Please reference corrective action for W 104 on page 3	

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W 102	Continued From page 2 This CONDITION is not met as evidenced by: Governing Body and Management failed to: exercise general policy, budget, and operating direction over the facility (W104). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services.	W 102	Please reference corrective action for W 104 on page 3	
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and interview the governing body and management failed to assure operating direction over the facility by failing to provide services and supports to assure the individual program plans for clients were consistently implemented and failed to provide protections from unnecessary chemical and physical restraints for clients. The findings are: A. The facility failed to provide statutorily mandated Active treatment services for 3 of 3 audit clients (#2, #3, #5)residing in the facility. Cross refer W195. B. The Governing Body failed to provide statutorily mandated Client Behavior and Facility practices for 3 of 3 audit clients (#2, #3, #5). Cross refer W266.	W 104	The noted deficiency will be corrected by the following actions: A. Helmsdale Management Team will develop a daily schedule to include the opportunities of positive active engagement for all Helmsdale residents. B. Helmsdale Management Team will conduct an leisure inventory for each resident to assist with providing meaningful leisure activities for all residents. C. Helmsdale Management Team will provide training and testing on Active Treatment requirements. D. CS will re-evaluate and if needed, re-asses the programming needs of each individual. Once identified, training needs will be prioritized and implemented accordingly. Any training need not immediately implemented, may be designated as a long range goal to be implemeted at a later time. E. Helmsdale Management will provide training specific to each residents active treatment needs. This training is to be outlined in core compentecies training that will cover, but not be limited to programming goals such as money management, diets, toileting, dining, toothbrushing,clothing care, meal, prep, and behavioral interventions. F. Documentation related to active programming will be completed on data sheets provided by clinical personnel.	9/1/2018
W 126	PROTECTION OF CLIENTS RIGHTS	W 126	G. RM and/or CS will monitor documentation 3x/ weekly. PM wil monitor weekly.	

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W 126	Continued From page 3 CFR(s): 483.420(a)(4) The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 2 of 3 audit clients (#3, #5) were taught to manage money to the extent of their capabilities. The findings are: 1. Client #3 was not provided training in the area of money management. Review on 7/18/18 of client #3's individual program plan (IPP) dated 10/26/17 revealed the following priority training needs: toothbrushing, self-medication, laundry, participation in leisure activities with peers and money management. Further review of the IPP revealed the following written training programs: Engaging in a preferred activity during leisure time, toothbrushing, laundry, bathing and participation in self administration of medication. There was no training program to address the priority need to improve money management. Review on 7/18/18 of client #3's adaptive behavior inventory (ABI) dated 11/2/16 revealed he is dependent on staff in all areas of money management. Interview on 7/18/18 with facility management staff revealed client #3 did not have a training program in the area of money management.	W 126	Please see page 3	

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W 126	Continued From page 4 2. Client #5 was not provided training in the area of money management. Review on 7/18/18 of client #5's IPP dated 3/27/18 revealed the following priority training needs: toothbrushing, self-medication, toileting, self bathing and in home safety. Further review of the IPP revealed the following goals: toothbrushing, self medication, bathing and toileting. There was no training program to address the priority need to improve money management. Review on 7/18/18 of client #5's ABI dated 2/20/18 revealed client #5 is dependent in all areas of money management. During an outing on 7/17/18 staff assisted client #5 in purchasing a bag of chips at a local store. He stood at the store counter with change (coins) and looked at the cashier. The Direct care staff took the change out of his hand and counted out the coins to make the purchase. Interview on 7/18/18 with facility management staff revealed client #5 did not have a training program in the area of money management.	W 126	See page 3	
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The facility failed to assure: each client received a continuous active treatment program, which	W 195	See page 6	

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W 195	Continued From page 5 included aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that was directed towards the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible (W196); ensure for 1 of 3 audit clients (#3) individual program plan's (IPP) included specific objectives to address using utensils and use of protective equipment; (W227); assure 3 of 3 audit clients (#2, #3, #5) received a continuous active treatment program consisting of supports and services in sufficient number to support the individual program plans (W249) and the Human rights committee minutes failed to review and monitor 3 of 3 sampled clients (#2, #3, #5) behavior support plans (BSPs), which included the restriction of clothing, protective helmet use and investigations of allegations of abuse (W264). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to the clients.	W 195	The noted deficiency will be corrected by the following actions: A. Clinical Supervisor will re-evaluate, and if needed ensure re-assements involving toileting, leisure activities, dining, clothing care, and behavioral interventions are completed by the appropriate consultant. B. Clinical Supervisor will re-evaluate, and if needed, re-assess Behavioral Support Plans (BSPs) to ensure implementation of psychotropic medications, protective equipment use, and allegations of abuse. C. If needed, Clinical Supervisor will ensure support plans are revised where needed to ensure proper program implementation. For example, BSPs will be evaluated to ensure specific information related to the use of psychotropic medication and its evaluation. D. Use of protective equipment will be revised to inlcude documentation that outlines appropriate time intervals for continuos use. E: All Rights Restrictions will be reassesed to see if they remain appropriate. If in place, restrictions will be reviewed by HRC quarterly. Restrictions could inlcude, but not limited restrictions on clothing and protective helmet use. If right restrictions are implemented, programming will be developed to work towards removing the restriction in the future. F. All abuse/neglect investigations will be reviewed by Human Right's Committee as they occur. Documentation of meeting minutes to occur monthly. G. Clinical Supervisor will review documentation and monitor regarding the above items 3x/ weekly.	9/1/18
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression	W 196	H. Program Manager to review documentaion and monitor regarding the above tems weekly.	

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W 196	Continued From page 6 or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, record review and confirmed by interviews with staff, the facility failed to provide an aggressive implementation of specialized treatment to 3 of 3 audit clients (#2, #3, #5) in the area of toileting, leisure, dining, clothing care and behavioral intervention. The findings include: 1. Cross reference W249. The facility failed to ensure 3 of 3 audit clients (#2, #3, #5) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the area of toileting, diets and structured leisure choices. 2. Cross reference W264. The HRC meeting minutes failed to reflect review and monitoring of 3 of 3 sampled clients (#2, #3 and #5) behavior support plans (BSPs), which included the use of psychotropic medications, protective helmet use and investigations of allegations of abuse.	W 196	Please see page 6, W195.	
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure for 1 of 3	W 227	See page 8	

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W 227	Continued From page 7 audit clients (#3) individual program plan's (IPP) included specific objectives to address using utensils and use of protective equipment. The findings include: 1. The IPP did not provide training for client #3 to learn to use a knife cut up his food independently. During observations in the facility on 7/18/18 during breakfast client #3 sat at the dining room table and was assisted in serving pancakes and syrup. He picked up the pancakes and bit pieces off large of the pancakes. At no time during the meal did the 3 direct care staff in the dining room offer to assist him with cutting up his food. Review on 7/18/18 of his adaptive behavior inventory (ABI) dated 11/2/16 revealed client #3 requires assistance using a knife to cut up his food. Interview on 7/18/18 with direct care staff revealed client #3 requires verbal cues to consistently use his knife to cut up his food. 7. Client #3's interdisciplinary team failed to develop a goal for him to clean his helmet as discussed at his IPP. Review on 7/18/18 of client #3's IPP dated 10/26/17 revealed the team discussed a need to develop a goal for client #3 to clean his protective helmet; however, review of his written goals revealed no written formal program. Interview on 7/18/18 with the QIDP confirmed a goal for client #3 to clean his helmet had not been developed at his IPP.	W 227	The noted deficiency will be corrected by the following actions: A. CS will re-evaluate and if needed, re-asses the adaptive equipments needs of each individual. Once identified and if needed, home will purchase and any adaptive eaquipment that is needed. B. When appropriate, CS will implement programming goals that will integrate the use of each individuals adaptive equipment. C. CS and/or contracted consultant will provided training on how to properly use and incorporate adaptive equipment use. This training will include, but not be limited to meal preparation, active treatment during dining activities, adaptive equipment, and adaptive equipment maintenance. D. CS will implement a system (including documentation) in which adaptive equipment is routinely checked to ensure cleanliness and that functions properly. E. RM and/or CS will monitor documentation 3x/ weekly. PM wil monitor weekly.	9/1/18

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W 249	Continued From page 8	W 249		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure 3 of 3 audit clients (#2, #3, #5) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plans (IPPs) in the area of toileting, toothbrushing, diets and structured leisure choices. The findings are: 1. Direct Care staff did not offer client #5 a variety of leisure opportunities as per his IPP. During observations in the facility on 7/17/18 from 8:30am-11:30am client #5 slept in an ottoman in the living room or walked around the facility holding a piece of paper. He was not engaged in other activities during this time. At 11:35am direct care staff asked him to join another client for an outing to a department store. During observations in the facility on 7/18/18 from 8:30am until 9:30am client #5 slept on an ottoman in the living room. No other leisure choices were offered to him.	W 249	Please see page 3, W104 and page 6, W195.	

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W 249	Continued From page 9 Review on 7/18/18 of client #5's individual program plan (IPP) dated 3/27/18 revealed he had the following priority training needs: toothbrushing, self medication, toileting, self bathing. Further review of the IPP revealed training programs to brush teeth with 50% accuracy for 6 consecutive months, to complete self medication, to complete bathing with 20% accuracy for 6 consecutive months and a toileting program which required 75% verbal cues for 6 consecutive months. Further review of the IPP revealed client #5 should be provided a variety of activities. Interview on 7/17/18 with the Residential Manager (RM) revealed direct care staff should offer client #5 a variety of leisure activities from which to make a choice. Interview on 7/18/18 with the qualified intellectual disabilities professional (QIDP) confirmed staff should be offering leisure activities to client #5 during unstructured leisure time. He confirmed client #5 has been home during the day all day since mid June when public school dismissed. Additional interview confirmed there is no daily schedule of activities other than the outings that are on the activities schedule for the month of July. 2. Direct care staff did not follow client #5's toileting schedule. During observations on 7/17/18 from 8:30am-11:30am, staff did not prompt client #5 to go to the bathroom for toileting. Several times an incontinent brief could be seen underneath the waistband of his pants.	W 249	Please see page 3, W104 and page 6, W195.	

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W 249	Continued From page 10 Review on 7/18/18 of client #5's individual program plan (IPP) dated 3/27/18 revealed he had the following priority training needs: toothbrushing, self medication, toileting, self bathing. Further review of the IPP revealed a training program to use the toilet every 2 hours which required 75% verbal cues for 6 consecutive months. Review on 7/18/18 of nursing notes dated 2/17/18 and 6/14/18 revealed client #5 was treated for diaper rash on his buttocks. Interview on 7/18/18 with the RM revealed direct care staff should be taking client #5 to the bathroom to sit on the toilet every 2 hours in conjunction with his toileting schedule. The RM confirmed there is no written documentation of the toileting schedule for client #5. The RM stated client #5 wears incontinent briefs and does not indicate when he is wet or soiled. Further interview confirmed client #5 has been treated for recurrent diaper rash in the past several months. The RM stated, "We don't know why he keeps getting diaper rash." 3. Staff did not follow client #5's diet consistency during lunch observations on 7/18/18. During observations on 7/17/18 at 12:20pm direct care staff cut a turkey and cheese sandwich into 4 sections and put it in a built up sectioned plate in the dining room at client #5's place setting. Client #5 tore sections of the sandwich up and ate the sandwich pieces. Review on 7/18/18 of client #5's IPP dated 3/27/18 revealed he receives a regular diet with	W 249	Please see page 3, W104 and page 6, W195.	

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W 249	Continued From page 11 quarter sized pieces of meat. Interview on 7/18/18 with the QIDP revealed client #5's diet is current and should be followed. 4. Staff did not provide leisure options for client #3 throughout morning observations on 7/18/18. During morning observations on 7/18/18 at 7:20am client #3 indicated he wanted to go back to bed. Client #3 climbed back into bed. At 10:00am, when the surveyor knocked on his bedroom door, he was lying in bed wearing his adaptive helmet. Staff indicated he had been in his bedroom since he had brushed his teeth at 7:20am. No leisure options were provided to client #3 during this time. Interview on 7/18/18 with the Residential manager indicated client #3 was out of school and that all of the clients had unstructured leisure time in the mornings between breakfast and lunch. She indicated most of the community based activities took place in the afternoons on second shift. Record review on 7/18/18 of client #3's IPP dated 10/26/17 revealed he has priority training needs to improve toothbrushing, participate in self medication, complete laundry tasks, improve money management and participate in leisure activities with his peers. Under the service supports section, the IPP revealed, "Staff should encourage [client #3] to use his tablet and gestures with peers and staff at residential facility and in public areas."	W 249	Please see page 3, W104 and page 6, W195.	

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(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 249	Continued From page 12 5. Client #3 did not receive assistance with toothbrushing as per his IPP. During observations in the facility on 7/18/18 at 7:18am, direct care staff took client #3 into the bathroom to brush his teeth. Client #3 took the toothbrush and staff assisted him in putting the toothpaste on his toothbrush. After brushing for one minute staff helped him to take his toothbrush and toothpaste into his room to put it away. Review on 7/18/18 of client #3's IPP dated 10/26/17 revealed he had priority training needs in toothbrushing, self-medication, laundry, money management, leisure activities with his housemates. Further review revealed formal programs in toothbrushing, participating in leisure activities with peers, bathing, laundry, and self-medication. Additional review on 7/18/18 of client #3's IPP revealed his toothbrushing program requires direct care staff go back over his teeth hand over hand to ensure he does a thorough job. Review on 7/18/18 of the ABI dated 11/2/16 revealed he requires assistance with toothbrushing. Interview on 7/18/18 with the qualified intellectual disabilities professional (QIDP) revealed direct care staff should should be implementing his toothbrushing program as written. 6. Direct care staff did not provide opportunities for clients to participate in meal preparation on 7/18/18 during breakfast.	W 249	Please see page 3, W104 and page 6, W195.	

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	34G253	A. BUILDING _____ B. WING _____	07/18/2018

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W 249	Continued From page 13 During observations in the facility on 7/18/18 during breakfast preparation, direct care staff took eggs out of the refrigerator and took pancakes out of the freezer. Staff cracked eggs, stirred them and put pancakes on a pan and put the pancakes into the oven. Staff never asked clients to participate in assisting with meal preparation. Client's #3 and #5 sat at the dining room table and walked into the kitchen. Direct care staff told both clients to go sit down and wait. Review on 7/18/18 of client #5's ABI revealed he is dependent on staff to assist him in making food requiring stirring and mixing and putting food into the oven. Interview on 7/18/18 with direct care staff revealed client #5 can get items out of the refrigerator, stir food in a bowl, put bread on a pan and assist with putting items in the oven with staff assistance. 7. Client #2 was not provided opportunities for leisure choices. During observations on 7/17/18 from 8:30am-12:05pm, client #2 was in his bedroom sleeping. Staff went back to his bedroom several times and knocked on his bedroom door but leisure options outside of his bedroom were not provided to him. Review on 7/18/18 of client #2's IPP dated 1/19/18 revealed he has the following priority needs: Medication Administration, Oral Hygiene, Bathing, Leisure and Toileting. Further review of the IPP revealed he enjoys listening to music. Interview on 7/18/18 with the Residential	W 249	Please see page 3, W104 and page 6, W195.	

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W 249	Continued From page 14 manager revealed client #2 likes to sleep and stay in his bedroom. She stated all of the clients are out of school until late July. Further interview revealed staff have several leisure options they can offer client #2. She stated often they go out into the community on the afternoon shift when it is not too hot outside. 8. Client #2's toileting schedule was not implemented consistently. During observations in the facility on 7/17/18, client #2 remained in his bedroom from 8:30am until 12:05pm. Staff went back to his bedroom several times and knocked on his bedroom door to check on him several times. At 12:15pm, direct care staff came out of his bedroom (which does not have a bathroom) with a trash bag that had an incontinent brief visible inside the bag. Staff was wearing gloves. Staff took the gloves off and took the trash bag outside to the trash can. At no time during this period did staff walk client #2 to the bathroom. During observations from 5:50am-10am at the facility on 7/18/18 client #2 came out of his bedroom for medication administration, the breakfast meal and to briefly play a game on the floor in the living room. Staff walked back and forth to his bedroom several times to check on him while he was in the bedroom. Staff were overheard to tell client #2, "lets go get you changed." Staff walked client #2 to his room and came out of the bedroom with a trash bag. Interview on 7/17/18 with direct care staff revealed client #2 wears incontinent briefs. Interview on 7/18/18 with the Residential	W 249	Please see page 3, W104 and page 6, W195.	

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W 249	Continued From page 15 manager revealed client #2 is on a toileting schedule and should be taken to the bathroom every 2 hours to sit on the toilet. Interview on 7/18/18 with the QIDP revealed client #2 is on a toileting schedule and should be taken to the bathroom every 2 hours for toileting.	W 249	Please see page 3, W104 and page 6, W195.	
W 264	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(iii) The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on review of Human Rights Committee (HRC) minutes, verified by review of record and by interview, the HRC meeting minutes failed to reflect review and monitoring of 3 of 3 sampled clients (#2, #3, #5) behavior support plans (BSPs), which included the restriction of clothing, protective helmet use and investigations of allegations of abuse. The findings are: 1. Review of human rights committee minutes dated 6/18/18 revealed there was no discussion of an investigation regarding allegations of mistreatment to client #5. Review on 7/18/18 of an investigation dated 5/17/18 revealed allegations of mistreatment to	W 264	The noted deficiency will be corrected through the following actions: A. Clinical Supervisor will re-evaluate, and if needed re-assess Behavioral Support Plans (BSPs) to include restriction of clothing, protective helmet and time intervals of use, and investigations of allegations of abuse. B. All Restrictions will be reassesed to see if they remain appropriate. If in place, restrictions will be reviewed by HRC quarterly. Restrictions could inlcude, but not limited restrictions on clothing and protective helmet use. If right restrictions are implemented, programming will be developed to work towards removing the restriction in the future. C. All abuse/neglect investigations will be reviewed by Human Right's Committee as they occur. Documentation of meeting minutes to occur monthly. D. Clinical Supervisor will review documentation and monitor regarding the above items 3x/ weekly. E. Program Manager to review documentaion and monitor regarding the above tems weekly.the	9/1/18

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W 264	Continued From page 16 client #5. Further review of this investigation revealed the initial allegations involved a direct care staff shoving client #5 into a cab providing transport services to the school. Further review revealed a direct care staff was also accused of throwing client #5's bookbag at him in the cab. The results of this internal investigation revealed these allegations were substantiated and the direct care staff was terminated. Review on 6/18/18 of the human rights committee minutes revealed this investigation was not discussed at this meeting. Interview on 7/18/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed this investigation was not reviewed with the HRC. Further interview revealed all investigations involving possible abuse, mistreatment, neglect and exploitation are usually discussed with the HRC. 2. The HRC did not discuss removing client #2's clothing from his room due to property misuse. During observations at the facility on 7/17/18 and 7/18/18 direct care staff went into the garage to retrieve client #2 's clothing. Clothing was folded on shelves and hung on racks in the garage area. Interview on 7/18/18 with the Residential Manager confirmed this was client #2's clothing and that it was kept in the garage due to client #2 misusing and destroying clothing items. She did not know if this had been discussed with the HRC. Review on 1/19/18 of client #2's IPP dated 1/19/18 revealed no information about client #2's	W 264	See page 16	

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W 264	Continued From page 17 clothing being removed from his bedroom. Review on 7/18/18 of client #2's BSP dated 3/13/18 revealed the following target behaviors: physical aggression, property destruction, inappropriate verbalizations, self-injurious behavior and spitting. There was no information regarding client #2's clothing being removed from his bedroom. Review of HRC minutes dated 3/19/18, 4/16/18 and on 6/18/18 revealed client #2's clothing restriction had not been discussed with the HRC. 3. The HRC did not discuss ongoing protective helmet use for client #3. Throughout observations on 7/17/18 from 8:30am-11:00am (He left on an outing with his Mom at 11am) client #3 wore his protective helmet with a face guard. During observations on 7/18/18 from 6:00am-10:30am client #3 wore his adaptive helmet with the exception of medication administration and mealtime. For example: On 7/18/18 client #3 indicated he wanted to go back to bed after toothbrushing. Client #3 went back to his bedroom and got on his bed. At 10:00am, when the surveyor knocked on his bedroom door, he was lying in bed wearing his adaptive helmet. Staff indicated he had been in his bedroom since he had brushed his teeth. During observations on 7/18/18 from 6:00am-10:30am client #3 wore his adaptive helmet with the exception of medication administration and mealtime.	W 264	See page 16	

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W 264	Continued From page 18 Review on 7/18/18 of client #3's behavior support plan dated 10/26/17 revealed client #3 is to wear his protective helmet when he engages in head banging when other attempts to redirect his behavior have failed. Further review revealed client #3 will wear his helmet until he discontinues head banging or up to a 60 minute maximum. Once headbanging has stopped or after one hour, staff are instructed to remove the helmet. Staff are also instructed to check his head, scalp or face for injury or irritation. Additionally, staff are instructed that the helmet should remain off for at least 4 hours. Interview on 7/18/18 with the QIDP confirmed this behavior support plan that addresses self-injury is still current. Additional interview confirmed client #3 "feels safe" in his helmet and he wears the protective helmet most of the time. Additional interview confirmed this is not in conjunction with the BSP however this has not been discussed with the Psychologist or the HRC.	W 264	See page 16	
W 266	CLIENT BEHAVIOR & FACILITY PRACTICES CFR(s): 483.450 The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: The facility failed to: assure that all techniques used to manage behaviors are integrated into an active treatment program (W288), assure a record of restraint checks and usage were kept on the use of a protective helmet for 1 of 3 audit clients (W303), assure staff provided	W 266	Please reference corrective action for W 288, W 303, W 306, and W 312	9/1/2018

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W 266	Continued From page 19 opportunities for motion and exercise for a period of not less than 10 minutes during each two hour period in which a restraint (protective helmet) was worn for 1 of 3 audit clients (W306) and assure that drugs used for control of inappropriate behavior were used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed (W312). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated Client Behavior and Facility Practices to its clients.	W 266	See page 19	
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure that all techniques used to manage behaviors were integrated into an active treatment program. This affected 2 of 3 audit clients (#2, #5). The findings are: 1. Client #2's interdisciplinary team did not include a technique of removing his clothing from his bedroom into his active treatment program. During observations at the facility on 7/17/18 and 7/18/18 direct care staff went into the garage to	W 288	The noted deficiencies will be corrected by the following actions: A. Clinical supervisor will re-assess the programming needs of each individual, specifically as it applies to Behvaior Management. Once identified, team will implement and/or revise Behavior Support Plans (BSPs) to inlcude crisis plans that address the use of PRN medications, detailed parameters in which PRN medication is to be given, and the evaluation of its use. B. Clinical Supervisor will re-evaluate rights restrictions that include clothing, and protective helmet and time intervals of use. If right restrictions are implemented, programming will be developed to work towards removing the restriction in the future. Programming and subsequent documentation will be developed to accurately track the use of restrictive adaptive equipment (i.e. helmet, protective glove, etc.	9/1/2018

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W 288	Continued From page 20 retrieve client #2 's clothing. Clothing was folded on shelves and hung on racks in the garage area. Review on 1/19/18 of client #2's individual program plan (IPP) dated 1/19/18 revealed no information about client #2's clothing being removed from his bedroom. Review on 7/18/18 of client #2's BSP dated 3/13/18 revealed the following target behaviors: physical aggression, property destruction, inappropriate verbalizations, self-injurious behavior and spitting. There was no information regarding client #2's clothing being removed from his bedroom. Interview on 7/18/18 with the Residential Manager confirmed this was client #2's clothing and that it was kept in the garage due to client #2 misusing and destroying clothing items. She did not know if this had been discussed with the HRC. 2. The use of a PRN medication for client #5 was not included in his active treatment program. Review on 7/18/18 of client #5's physician orders dated 5/15/18 revealed a PRN order for Lorazepam 0.5 milligrams for agitation. Review on 7/18/18 of a medication administration history for client #5's Lorazepam revealed this medication had been given 17 times since April 27, 2018 for agitation. Review of client #5's behavior support program dated 3/27/18 did not include a crisis plan incorporating the use of this medication into client #5's active treatment program.	W 288	Continued from page 20 D. Clinical Supervisor will audit behavior and medication data on a monthly basis to determine whether or not a PRN should be administered routinely. If/ when needed, CS and RN will contact prescribing physician to discuss any potential changes. E. Helmsdale Management Team will provide training and testing on support plan requirements. F. RM and/or CS will monitor documentation 3x/ weekly. PM will monitor weekly.	

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W 288	Continued From page 21 3. The use of a PRN medication was not included in client #2's active treatment program. Review on 7/18/18 of client #2's physician orders dated 5/24/18 for Haloperidol 0.5mg twice daily PRN for agitation. Review on 7/18/18 of a medication administration history for client #2's PRN indicates Haloperidol was given 25 times since 5/21/18. Review of client #2's behavior support program dated 3/13/18 did not include a crisis plan incorporating the use of this medication into client #2's active treatment program.	W 288	See page 20 and 21.	
W 303	PHYSICAL RESTRAINTS CFR(s): 483.450(d)(4) A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to assure a record of restraint checks and usage were kept on the use of a protective helmet for 1 of 3 audit clients (#3). The finding is: Staff did not keep a record of client #3's protective helmet use. Throughout observations on 7/17/18 from 8:30am-11:00am (He left on an outing with his Mom at 11am) client #3 wore his protective helmet with a face guard. There were no attempts to head bang during this observation.	W 303	Please see page 6, W195	9/1/2018

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W 303	Continued From page 22 During observations on 7/18/18 from 6:00am-10:30am client #3 wore his adaptive helmet with the exception of medication administration and mealtime. For example: On 7/18/18 client #3 indicated he wanted to go back to bed after toothbrushing. Client #3 went back to his bedroom and got on his bed. At 10:00am, when the surveyor knocked on his bedroom door, he was lying in bed wearing his adaptive helmet. Staff indicated he had been in his bedroom since he had brushed his teeth. There were no attempts to head bang during this observation. Review on 7/18/18 of client #3's behavior support plan (BSP) dated 10/26/17 revealed client #3 is to wear his protective helmet when he engages in head banging when other attempts to redirect his behavior have failed. Further review revealed client #3 will wear his helmet until he discontinues head banging or up to a 60 minute maximum. Once headbanging has stopped or after one hour, staff are instructed to remove the helmet. Staff are also instructed to check his head, scalp or face for injury or irritation. Additionally, staff are instructed that the helmet should remain off for at least 4 hours. Interview on 7/18/18 with the residential manager (RM) and the qualified intellectual disabilities professional (QIDP) revealed there is no record of client #3's helmet use. Further interview revealed, "he feels safe in his helmet." Additional interview revealed client #3 has been out of school since June and the home had adapted the schools daily helmet use schedule but it was not consistently used by direct care staff.	W 303	Please see page 20 an 21.	
W 306	PHYSICAL RESTRAINTS	W 306	Please see page 6, W195	9/1/2018

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W 306	Continued From page 23 CFR(s): 483.450(d)(6) Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to assure staff provided opportunities for motion and exercise for a period of not less than 10 minutes during each two hour period in which a restraint (protective helmet) was worn for 1 of 3 audit clients (#3). The finding is: Staff did not provide opportunities for motion and exercise for client #3 who wears a protective helmet. Throughout observations on 7/17/18 from 8:30am-11:00am (He left on an outing with his Mom at 11:00am) client #3 wore his protective helmet with a face guard. There were no attempts to head bang during this observation. During observations on 7/18/18 from 6:00am-10:30am client #3 wore his adaptive helmet with the exception of medication administration and mealtime. For example: On 7/18/18 client #3 indicated he wanted to go back to bed after toothbrushing. Client #3 went back to his bedroom and got on his bed. At 10:00am, when the surveyor knocked on his bedroom door, he was lying in bed wearing his adaptive helmet. Staff indicated he had been in his bedroom since he had brushed his teeth. There were no attempts to head bang during this observation.	W 306	See page 23	

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W 306	Continued From page 24 Interviews on 7/17/18 and on 7/18/18 with direct care staff revealed conflicting reports of whether client #3 wears his helmet when he is sleeping. Two staff interviews indicated client #3 does not wear his helmet when he is sleeping. One staff interview indicated sometimes client #3 prefers to sleep with his helmet on at night. Three staff interviews indicated direct care staff check client #3 every 30 minutes when he is sleeping. Review on 7/18/18 of client #3's behavior support plan dated 10/26/17 revealed client #3 is to wear his protective helmet when he engages in head banging when other attempts to redirect his behavior have failed. He will wear his helmet until he discontinues head banging or up to a 60 minute maximum. Once headbanging has stopped or after one hour, remove the helmet. Check his head, scalp or face for injury or irritation. The helmet should remain off for at least 4 hours. Interview on 7/18/18 with the residential manager (RM) and the qualified intellectual disabilities professional (QIDP) revealed there is no record of client #3's helmet use. Further interview revealed, " he feels safe in his helmet." Additional interview revealed client #3 has been out of school since June and the home had adapted the schools daily helmet use schedule but it was not consistently used by direct care staff. The RM stated client #3 can take the helmet off but often needs assistance putting the helmet back on. Additional interview revealed client #3 does not sleep with his helmet on.	W 306	See page 23	