STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL049-123	A. BUILDING: _____ B. WING _____	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMS HOUSE	611 PRESBYTERIAN ROAD MOORESVILLE, NC 28115

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 11/28/18. The complaint (intake # NC00145285) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were held at least quarterly and repeated for each shift. The findings are: Review on 11/27/18 of facility's fire drill log from 1/19/18-10/27/18 revealed:	V 114		

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V 114	Continued From page 1 - During the 1st quarter of 2018 (January - March), the facility failed to hold a fire drill during 3rd shift - During the 2nd quarter of 2018 (April - June), the facility failed to hold a fire drill during 2nd shift - During the 3rd quarter of 2018 (July - September), the facility failed to hold a fire drill during 1st shift Review on 11/27/18 of the facility's disaster drill log from 1/19/18-10/27/18 revealed: - During the 1st quarter of 2018 (January - March), the facility failed to hold a disaster drill during 3rd shift - During the 2nd quarter of 2018 (April - June), the facility failed to hold a disaster drill during 2nd shift - During the 3rd quarter of 2018 (July - September), the facility failed to hold disaster drill during 1st shift Interview on 11/28/18 with Qualified Professional #2 (QP#2) revealed: - Staff were instructed to hold fire and disaster drills as the rule required - Going forward, drills would be held as required.	V 114		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be	V 293		

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V 293	Continued From page 2 awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.	V 293		

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V 293	Continued From page 3	V 293		

This Rule is not met as evidenced by:
Based on record review and interview, the residential treatment staff secure failed to coordinate with other individuals and agencies with the child or adolescents's system of care affecting 1 of 4 clients (client #1). The findings are:

Review on 11/26/18 of client #1's record revealed:
- An admission date of 10/4/18
- Diagnoses of Bipolar Disorder, Current or Most Recent Episode, Hypomanic and Post Traumatic Stress Disorder
- Client #1 was in the legal custody of a Department of Social Services (DSS)
- Contact information (a telephone number and email address) for client #1's DSS social worker
- Client #1 was 17 years of age

Interview on 11/28/18 with client #1's DSS social worker revealed:
- On 10/25/18, she received a phone call from a Psychiatric Residential Treatment Center (PRTF) staff regarding client #1
- She learned that client #1 had swallowed a piece of necklace, which then had to removed via a medical procedure at a local hospital on 10/23/18
- As a result of client #1's attempt to harm herself by swallowing the piece of necklace, hospital staff had initiated Involuntary Commitment (IVC) procedures on behalf of client #1 and on 10/24/18, client #1 was transported to a PRTF
- She sent an email to the administrative

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assistant at client #1's facility to ask why no one from the facility had notified her about what had happened to client #1
- On 10/26/18, she received a voice mail message from the facility's AP regarding the incident on 10/22/18, the medical procedure that was preformed and client #1's transfer to the PRTF
- She felt that as a representative of the legal guardian of client #1, someone from the facility should have informed her of the situation involving client #1 prior to 10/26/18.
-

Interview on 11/28/18 with staff #1 revealed:
- She had not contacted the DSS social worker for client #1
- She knew that the Associate Professional (AP) had attempted to contact the DSS social worker and had documented her attempts to reach the social worker.

Interview on 11/28/18 with the AP revealed:
- A "few days later" (after the events of 10/22/18) she was instructed to contact client #1's social worker
- She did not report who instructed her to call the DSS social worker
- She was aware that client #1's care coordinator was aware of the client #1's situation as the care coordinator had spoken with the Qualified Professional #1 (QP #1) on 10/23/18
- She assumed that the care coordinator had informed client #1's social worker
- Upon being instructed to call client #1's social worker, she did and left a telephone message for the social worker (no date provided).

Interview on 11/26/18 with Qualified Professional #1 (QP #1) revealed:
- Staff informed her on the morning of

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V 293	Continued From page 5 10/23/18, client #1 had to be transported to a local hospital on the evening of 10/22/18 because she was experiencing chest pains - Client #1 disclosed to staff #1 that her chest pains were the result of her having intentionally swallowed a piece of her necklace - Staff #1 transported client #1 to a local hospital for medical evaluation and treatment on 10/22/18 - At the hospital, it was determined that client #1 had indeed swallowed a piece of her necklace and it would have to be removed via a medical procedure - Because client #1 had swallowed the piece of her necklace as an attempt to harm herself, hospital personnel decided to pursue an involuntary commitment on behalf of client #1 instead of discharging client #1 back to the facility - On 10/23/18, she received a telephone call from client #1's care coordinator to discuss client #1's situation and during the course of the conversation, client #1's care coordinator reported that client #1's DSS social worker had contacted her and wanted to know why no one from the facility had contacted her to inform her of client #1's hospitalization on 10/22/18 - After learning client #1's DSS social worker had not been contacted, she then instructed the facility's Associate Professional (AP) to contact the DSS social worker - It was her understanding that the AP had attempted to reach the DSS social worker and had documentation of her attempts - She also spoken with staff #1 and learned that there had been some "confusion" as to who was going to contact DSS social worker and apparently it was never done - Although client #1's DSS social worker had apparently learned what had happened with client #1, it would have been best practice that	V 293		

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someone from the facility had ensured that the social worker had been informed immediately
- She could not provide the documentation of the AP's attempts to reach client #1's DSS social worker.

Interview on 11/28/18 with the Licensed Professional revealed:
- In working with different Department of Social Services and their social workers, several DSS's had different policies on when they wanted to be notified of any issues involving their clients
- Some social workers wanted to be notified immediately and others wanted to be called at the beginning of business on the following day (if the incident occurs after hours)
- Best practice would be to attempt to notify guardians/guardian representative at the time of the incident either via a phone call, email or call to their agency's emergency after hours number regardless of their wishes
- Doing this would ensure the facility had done its part to make sure social workers were made aware of any situations involving their clients as soon as possible.

Interview on 10/28/18 with the Operations Manager revealed:
- Staff may have been confused as to how quickly client #1's legal guardian should have been notified
- Some DSS social workers wanted to be notified immediately when there was an issue involving their client, regardless of the time of day or night
- Other social workers wanted the facility to wait until the following morning, especially if something happened overnight or during the early morning hours
- The AP had been directed to contact the DSS

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V 293	Continued From page 7 social worker but had failed to do so - The AP should have notified client #1's DSS social worker no later than the beginning of the following day (10/23/18) - It was his understanding that the AP had attempted to contact the DSS social worker; however, he could not provide any documentation of those attempts as he was waiting on the AP to provide him with this information.	V 293		