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| V 000 | 00 INITIAL COMMENTS | | V 000 | | | |
| | on 6/28/19. The comp (intake #NC00152026 This facility is license | w up survey was completed blaint was substantiated 6). Deficiencies were cited. d for the following service 27G .1700 Residential re for Children or | | | | |
| V 107 27G .0202 (A-E) Personnel Requirements | | sonnel Requirements | V 107 | | | |
| | 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all | | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | | X3) DATE SURVEY COMPLETED | |
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| V 107 | decision regarding en upon the offense in re which the applicant is (d) Staff of a facility of currently licensed, regaccordance with appliservices provided. (e) A file shall be mai employed indicating the shall be mained to the | ct of this information on a apployment shall be based elationship to the job for applying. or a service shall be gistered or certified in icable state laws for the intained for each individual the training, experience and or the position, including | V 107 | | | | |
| | facility failed to ensure was maintained for 4 #2, #3, and #4). The Review on 6/27/19 of revealed: -A hire date of 4/24/19 -No job description or indicated the staff me education was available Review on 6/27/19 of revealed: -A hire date of 4/25/19 -No job description or | ews and interviews, the e a complete personnel file of 5 audited staff (staff #1, findings are: staff #1's personnel record 9; documentation that t the minimum level of ole. staff #2's personnel record 9; | | | | | |

Division of Health Service Regulation

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| | OF DEFICIENCIES DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| V 107 | Continued From page 2 | | V 107 | | | |
| | education was availal | ble. | | | | |
| | revealed: -A hire date of 4/16/19 -No documentation the | staff #3's personnel record 9; hat indicated the staff met education was available. | | | | |
| | Review on 6/27/19 of staff #4's personnel record revealed: -A hire date of 5/8/19; -No job description or documentation that indicated the staff met the minimum level of education was available. | | | | | |
| | Interview on 6/28/19 with staff #1 revealed: -She had read and signed the job description for a Paraprofessional that was in her new hire packet; -She had submitted the information in her new hire packet to the Qualified Professional (QP) #1; -She had completed her high school education; -Approximately 1 1/2 weeks ago, the QP #2 had requested verification of her education; -"On my behalf, I haven't given it (proof of education) to her (the QP #2);" -She had not been asked to provide verification of her education prior to 1 1/2 week ago; -"[The QP #2] thought it was on record and I guess that's why she didn't make a big deal." | | | | | |
| | -She thought she had description for a Para sure; -She was interviewed -The QP #2 had sent | with staff #2 revealed: I read and signed the job professional, but she wasn't and hired by the QP #2; her a text message on she needed to sign a job de verification of her | | | | |

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education;

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| | OF DEFICIENCIES DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| V 107 | Continued From page | 3 | V 107 | | | |
| | -She had not been as her education prior to | ked to provide verification of 6/17/19. | | | | |
| | -She had completed h -She had been contact (6/27/19) by the QP # she had to provide ve -She had not been as her education prior to Interview on 6/28/19 s | 22 and was informed that rification of her education; sked to provide verification of today (6/27/19). with staff #4 revealed: | | | | |
| | description for a Para sure; -She had completed hand was enrolled in curve -She was interviewedThe QP #2 had required hire packet and return verification of education interviewed; -The QP #2 had followed of May 2019 to reshe still needed; | and hired by the QP #2; ested she complete a new it to her along with on when she was wed up with her around the emind her of information that | | | | |
| | -Until the past couple responsibility of the Clensure their personne to beginning work; -"In her (the QP #2) daware of what was not linterview on 6/27/19 she had not been into the couple of the coup | el files were complete prior lefense, she may not be leded (in personnel files)." with the QP #2 revealed: formed of what was required s before staff began working | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | ONSTRUCTION | | E SURVEY PLETED | |
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| V 107 | Interview on 6/27/19 revealed: -He was aware that with personnel recor he thought they had -"I thought I had farr records were comple working) out (to the clear enough;" -It had been discove that the QP #2 overs so they were now to along with the QP # together to hire emp -"My QP's are rushir through to get them | g through the personnel files sure they were complete. with the Operations Manager there were issues in the past rds not being complete, but gotten slightly better; med that (ensuring personnel ete before employees began QP #2) but I didn't make it ered during the past 2 weeks seeing hiring wasn't working king a team approach and he 1 and #2 were working loyees; and them (new employees) started." | V 107 | | | |
| V 108 | (g) Employee training provided and, at a model following: (1) general organiz (2) training on client delineated in 10A Notal Allowing to meet | on the standard of the standar | V 108 | | | |

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Division of Health Service Regulation

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 108 | Continued From page | e 5 | V 108 | | |
| | 5602(b) of this Subcl member shall be ava times when a client is member shall be trair including seizure man to provide cardiopulm trained in the Heimlic techniques such as the the American Heart A equivalence for reliev (i) The governing boo implement policies an reporting, investigating | ed under 10a NCAC 27G hapter, at least one staff ilable in the facility at all s present. That staff hed in basic first aid hagement, currently trained honary resuscitation and h maneuver or other first aid hose provided by Red Cross, hasociation or their ring airway obstruction. | | | |
| This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 4 of 5 audited staff (staff #1, #2, #3, and #4) had completed minimum employee training and failed to ensure at least 1 employee trained in basic first aid was available in the facility while clients were present affecting 5 of 5 audited staff (staff #1, #2, #3, #4, and #5). The findings are: Review on 6/27/19 of staff #1's personnel record revealed: -A hire date of 4/24/19; -No documentation the staff had completed training on how to meet the mh/dd/sa needs of the clients as specified in the treatment plan or training in basic first aid. | | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 6 of 54

| | | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| V 108 | Continued From page | e 6 | V 108 | | |
| | -She had not complete the mh/dd/sa needs caid; -She was scheduled | with staff #1 revealed: ted training on how to meet of the clients or basic first to complete basic first aid ut may not be able to attend ack of transportation. | | | |
| | revealed: -A hire date of 4/25/1 -No documentation the training on how to me | ne staff had completed eet the mh/dd/sa needs of ed in the treatment plan or | | | |
| | Interview on 6/28/19 with staff #2 revealed: -She had not completed training on how to meet the mh/dd/sa needs of the clients or basic first aid; -She was scheduled to complete basic first aid training on 6/29/19. | | | | |
| | revealed: -A hire date of 4/16/1 -No documentation the training on how to me | ne staff had completed eet the mh/dd/sa needs of ed in the treatment plan or | | | |
| | -She had not complet the mh/dd/sa needs of aid; | with staff #3 revealed: ted training on how to meet of the clients or basic first to complete basic first aid | | | |
| | Review on 6/27/19 of | f staff #4's personnel record | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| V 108 | Continued From page | e 7 | V 108 | | | |
| | revealed: -A hire date of 5/8/19 -No documentation the training on how to meethe clients as specified training in basic first at a linterview on 6/28/19 she had not complete the mh/dd/sa needs of aid; -She was aware that training scheduled for informed the QP #2 thattend due to her religion Saturdays; -"I'm hoping they scheduling for a day other Review on 6/27/19 of | the staff had completed the mh/dd/sa needs of ad in the treatment plan or aid. with staff #4 revealed: the draining on how to meet of the clients or basic first there was a basic first aid to 6/29/19 but she had that she was not able to gion not allowing her to work the staff had basic first aid | | | | |
| | revealed: -A hire date of 5/1/19 -No documentation the training in basic first a | e staff had completed | | | | |
| | Attempted interviews staff #5 were not succ | on 6/27/19 and 6/28/19 with cessful. | | | | |
| | 2019 revealed there v | the staff schedule for June were 6 shifts in which there e that had been trained in | | | | |
| | revealed: -She had checked wit (QP) #1 to ensure tha was correct and indic worked; | with the Office Administrator th the Qualified Professional at the June 2019 schedule ated the correct staff that and #5 were scheduled to | | | | |

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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY |
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| V 108 | Continued From page | e 8 | V 108 | | |
| | | | | | |
| | complete training in b | asic first aid on 6/29/19. | | | |
| | Interview on 6/28/19 or -Until the past couple responsibility of the County ensure their personne to beginning work; -"In her (the QP #2) daware of what was not aware to required to complete of the clients. Interview on 6/27/19 or -She had not been into be in personnel fille until approximately 2 -She had been going since that time to ensure the was aware that somplete training in miclients; | with the QP #1 revealed: of weeks, it had been the P #2 to hire staff and el files were complete prior defense, she may not be eeded (in personnel files); hat Paraprofessionals were training in mh/dd/sa needs with the QP #2 revealed: formed of what was required as before staff began working weeks ago; through the personnel files ure they were complete. with the Operations Manager taff were required to | | | |
| | basic first aid was alw | vays required to be | | | |
| | records were complet working) out (to the C I didn't make it clear of -It was discovered with weeks that the QP #2 personnel records was been changed and he #2 were working toge | thin the past couple of a coverseeing hiring and sen't working so that had a calong with the QP #1 and sether as a team; go them (new employees) | | | |

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| AND PLAN (| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (712) | CONSTRUCTION | (X3) DATE SURVEY |
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| V 108 | O8 Continued From page 9 | | V 108 | | |
| | This deficiency is cros | ssed referenced into 10 A ope (V293) for a Type B and | | | |
| V 112 | 27G .0205 (C-D) Assessment/Treatme | nt/Habilitation Plan | V 112 | | |
| | 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; | | | | |
| (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: | | | | | |

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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE S | |
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| V 112 | Continued From page 10 | | V 112 | | | |
| | | op and implement goals to ne clients affecting 1 of 4 ne findings are: | | | | |
| | -An age of 12 years of -An admission date of -Diagnoses included Disorder, Attention Dof Major Depressive Distant a history of sexual -A Comprehensive Cl | f 3/8/19; Post Traumatic Stress eficit Hyperactivity Disorder, corder, multiple personalities al and physical abuse; linical Assessment dated | | | | |
| | 9/5/18 revealed the c urinating on her cloth -A Comprehensive Cl | ing and in her room; | | | | |
| | Addendum dated 1/10 -"[Client #1] will I | 0/19 revealed: apse into different | | | | |
| | #1] will lapse into free of months;" | a teenage boy, who [client quently over the past couple | | | | |
| | is in this personality, addressed by [the bo | | | | | |
| | -"One is a baby; | it is reported that it does not enage boy personality;" | | | | |
| | -A Treatment Plan da goals of: | ted 2/27/19 that included the | | | | |
| | | earn personal boundaries viors to decrease instances | | | | |
| | of inappropriate sexuzero;" | al orsexualized behaviors to | | | | |
| | skills and be able to o | mprove her communication discuss feelings towards atric residential treatment | | | | |
| | facility into level 3 gro | oup home and learn to and desires in an appropriate | | | | |
| | manner in 3 of 5 situa | | | | | |
| | traumatic event as ev | ridenced by ability to function ersistent worries, flashbacks | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| V 112 | Continued From page | e 11 | V 112 | | |
| | and avoidance of eve | ent for 5 out of 7 days a week nths;" If to the client urinating on her | | | |
| | revealed: -Date/Time of Inciden -"In the middle of the left her room and tool let herself in the office closet and got the sci -"Client (#1) then cut boy;" | night client (#1) got bored, | | | |
| | floor in client #1's bed been urinating on the -She was not aware t urinating on her cloth -She had informed cli last 2 weeks that she floor and vent of her thad never been exhibit- -She thought she sho the Qualified Professi #1's presenting problem. | rofessional revealed: e process of replacing the droom because she had carpet and in the vent; hat client #1 had a history of ing and in her room; ent #1's therapist within the had started urinating on the bedroom and the behavior bited before; full have been notified by ionals (QP) of all of client | | | |
| | -She was aware that urinating on her cloth -She was not sure wh Manager/Associate P made aware; | | | | |

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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | | (X3) DATE SURVEY COMPLETED |
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| UEL MC U | OUEE. | 611 PRE | SBYTERIAN ROAD | | |
| HELMS H | JUSE | MOORES | SVILLE, NC 28115 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE COMPLETE |
| V 112 | Continued From page | e 12 | V 112 | | |
| | brought to her attentical was her responsible received during the attreatment Plan based relay the information Manager/Associate Paraprofessionals. This deficiency is crowness of the corrected with the | rofessional and the essed referenced into 10A ope (V293) for a Type B and thin 45 days. | | | |
| V 118 | 27G .0209 (C) Medica | · | V 118 | | |
| | only be administered order of a person autidrugs. (2) Medications shall clients only when auticlient's physician. (3) Medications, incluadministered only by unlicensed persons transmistered to other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications are corded immediately MAR is to include the (A) client's name; (B) name, strength, and (C) instructions for activities. | istration: n-prescription drugs shall to a client on the written chorized by law to prescribe be self-administered by chorized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, regally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be or after administration. The following: | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 13 of 54

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE S | |
|--------------------------|--|--|---------------------|---|-------------|--------------------------|
| | | | A. BOILDING | | R- | _ |
| | | MHL049-123 | B. WING | | 1 | 8/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HELMS H | OUSE | | YTERIAN ROA | | | |
| | | | ILLE, NC 2811 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| V 118 | Continued From page | e 13 | V 118 | | | |
| | drug. (5) Client requests for checks shall be recor | person administering the medication changes or ded and kept with the MAR pointment or consultation | | | | |
| | failed to ensure 1 of 5 medication training properties affecting #2, #3, and #4). The face Review on 6/27/19 of revealed: -A hire date of 4/16/19 | ew and interviews the facility and interviews the facility and ited staff (#3) received rior to administering 4 of 4 clients (clients #1, findings are: I staff #3's personnel record 9; hat medication training had | | | | |
| | for the month of June | clients #2 and #3's MARs revealed staff #3 had ministered medications to | | | | |
| | -She had been admir clients; | with staff #3 revealed: sistering medications to medication training but was date of completion. | | | | |
| | | with clients #2 and #3 administered medications | | | | |
| | Interview on 6/27/19 | with the Qualified | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 14 of 54

| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|---------------------|---|-------------------------------|
| | | | A. BOILDING. | | R-C |
| | | MHL049-123 | B. WING | <u></u> | 06/28/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STATE | E, ZIP CODE | |
| HELMS H | OUSE | | BYTERIAN ROAL | | |
| | CLIMMADY CT | | VILLE, NC 28115 | | NI |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETE |
| V 118 | Continued From page | : 14 | V 118 | | |
| | | | | | |
| | _ | ssed referenced into 10A ope (V293) for a Type B and hin 45 days. | | | |
| V 131 | G.S. 131E-256 (D2) H Verification | ICPR - Prior Employment | V 131 | | |
| | REGISTRY (d2) Before hiring hea health care facility or health care facility sha | LTH CARE PERSONNEL alth care personnel into a service, every employer at a all access the Health Care and shall note each incident opriate business files. | | | |
| | facility failed to ensure Registry (HCPR) was of 5 audited staff (stati findings are: | ews and interviews, the ethe Health Care Personnel accessed prior to hire for 4 ff #1, #2, #3, and #4). The staff #1's personnel record | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 15 of 54

| | F OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|---------------------|---|-------------------------------|
| | | | A. BUILDING: _ | | D.O. |
| | | MHL049-123 | B. WING | | R-C 06/28/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | |
| HELMS H | OUSE | | YTERIAN ROA | | |
| | OLIMAN DV OT | | ILLE, NC 2811 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE |
| V 131 | Continued From page | e 15 | V 131 | | |
| | revealed: -A hire date of 4/25/1 -The HCPR was acce | essed on 5/17/19. | | | |
| | Review on 6/27/19 of revealed: -A hire date of 4/16/19 -The HCPR was acce | | | | |
| | | staff #4's personnel record | | | |
| | responsibility of the C ensure their personne to beginning work; -"In her (the QP #2) d | revealed: of weeks, it had been the | | | |
| | -She had not been into be in personnel file until approximately 2 -She had been going | with the QP #2 revealed: formed of what was required es before staff began working weeks ago; through the personnel files cure they were complete. | | | |
| | revealed: -He was aware that the with personnel record he thought they had garm records were completed. | with the Operations Manager here were issues in the past Is not being completed but gotten "slightly better;" ed that (ensuring personnel te before employees began QP #2) but I didn't make it | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 16 of 54

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---|---|-------------------------------|--|
| | | | 71. 501251110 | | R-C | |
| | | MHL049-123 | B. WING | | 06/28/2019 | |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HELMS H | OUSE | | YTERIAN ROA | | | |
| | | MOORESV | ILLE, NC 2811 | 5 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE | |
| V 131 | Continued From page | e 16 | V 131 | | | |
| | that the QP #2 overse so they were now tak along with the QP's # together to hire emplo -"My QP's are rushing through to get them s | them (new employees) | | | | |
| | | ssed referenced into 10A ope (V293) for a Type B and hin 45 days. | | | | |
| V 133 | G.S. 122C-80 Crimina | al History Record Check | V 133 | | | |
| | CHECK REQUIRED APPLICANTS FOR E (a) Definition As use "provider" applies to a program and any providevelopmental disabiliservices that is licens Chapter. (b) Requirement Ar provider licensed und applicant to fill a positiapplicant to have an econditioned on consectiminal history record the applicant has been less than five years, the is conditioned on concriminal history recordinational criminal history recordinational criminational criminationa | MPLOYMENT. ed in this section, the term an area authority/county vider of mental health, lity, and substance abuse able under Article 2 of this n offer of employment by a er this Chapter to an tion that does not require the occupational license is nt to a State and national d check of the applicant. If n a resident of this State for hen the offer of employment sent to a State and national d check of the applicant. The | | | | |

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 17 of 54 COUV11

| Division of | of Health Service Regu | lation | | | | |
|---|-------------------------|---|----------------------------|--|------------------|---|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED | |
| | | | | | R-C | |
| | | MHL049-123 | B. WING | | 06/28/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, STA | TE ZIP CODE | | |
| WAWL OF T | KOVIDER OR OUT FEEL | | SBYTERIAN ROA | | | |
| HELMS H | OUSE | | SVILLE, NC 281 | | | |
| | CLIMMA DV CT | | · · | | 1 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLET | Ē |
| V 133 | Continued From page | e 17 | V 133 | | | |
| | five years or more th | en the offer is conditioned | | | | |
| | | criminal history record | | | | |
| | check of the applican | • | | | | |
| | | who refuses to consent to a | | | | |
| | criminal history record | d check required by this | | | | |
| | • | nerwise provided in this | | | | |
| | | e business days of making | | | | |
| | | of employment, a provider | | | | |
| | - | t to the Department of | | | | |
| | Justice under G.S. 11 | | | | | |
| | | d check required by this it a request to a private | | | | |
| | | ate criminal history record | | | | |
| | _ | s section. Notwithstanding | | | | |
| | | Department of Justice shall | | | | |
| | | ational criminal history | | | | |
| | | ployment positions not | | | | |
| | covered by Public Lav | w 105-277 to the | | | | |
| | Department of Health | and Human Services, | | | | |
| | Criminal Records Che | | | | | |
| | - | eipt of the national criminal | | | | |
| | | the Department of Health | | | | |
| | | , Criminal Records Check | | | | |
| | | provider as to whether the | | | | |
| | | may affect the employability | | | | |
| | | case shall the results of the ory record check be shared | | | | |
| | | viders shall make available | | | | |
| | | tion that a criminal history | | | | |
| | | oleted on any staff covered | | | | |
| | | nty that has adopted an | | | | |
| | | nance and has access to | | | | |
| | | al Information data bank | | | | |
| | may conduct on beha | ılf of a provider a State | | | | |
| | criminal history record | d check required by this | | | | |

Division of Health Service Regulation

section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this

STATE FORM 6899 COUV11 If continuation sheet 18 of 54

| DIVISION | n Health Service Regu | ialion | 1 | | | |
|-------------------|--------------------------|--|------------------|--|-------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLE | ETED |
| | | | | | | _ |
| | | MUU 040 400 | B. WING | | R- | |
| | | MHL049-123 | | | 1 06/2 | 8/2019 |
| NAME OF PR | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| | | 611 PRES | BYTERIAN ROA | ΔD | | |
| HELMS HO | DUSE | | /ILLE, NC 281 | | | |
| | | | 1122, 110 201 | | . | |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | | DATE |
| | | | | DEFICIENCY) | | |
| 1/400 | 0 " 15 | 40 | 1// 400 | | | |
| V 133 | Continued From page | e 18 | V 133 | | | |
| | section within five bus | siness days of the | | | | |
| | conditional offer of en | nployment by the provider. | | | | |
| | | ormation received by the | | | | |
| | - | al and may not be disclosed, | | | | |
| | | nt as provided in subsection | | | | |
| | (c) of this section. For | | | | | |
| | | "private entity" means a | | | | |
| | business regularly en | • | | | | |
| | 9 , | d checks utilizing public | | | | |
| | records obtained from | | | | | |
| | | licant's criminal history | | | | |
| | | one or more convictions of | | | | |
| | | e provider shall consider all | | | | |
| | | s in determining whether to | | | | |
| | hire the applicant: | o dotogou.o. to | | | | |
| | (1) The level and serie | ousness of the crime. | | | | |
| | (2) The date of the cri | | | | | |
| | ` ' | rson at the time of the | | | | |
| | conviction. | | | | | |
| | (4) The circumstance: | s surrounding the | | | | |
| | commission of the cri | - | | | | |
| | | en the criminal conduct of | | | | |
| | the person and the jo | b duties of the position to be | | | | |
| | filled. | • | | | | |
| | (6) The prison, jail, pr | obation, parole, | | | | |
| | | ployment records of the | | | | |
| | | the crime was committed. | | | | |
| | • | ommission by the person of | | | | |
| | a relevant offense. | • | | | | |
| | The fact of conviction | of a relevant offense alone | | | | |
| | shall not be a bar to e | employment; however, the | | | | |
| | | considered by the provider. | | | | |
| | | lifies an applicant after | | | | |
| | | elevant factors, then the | | | | |
| | | e information contained in | | | | |
| | | cord check that is relevant | | | | |
| | | , but may not provide a copy | | | | |
| | of the criminal history | | | | | |
| | applicant. | . Start direct to the | | | | |
| | αμμιισαπι. | | 1 | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 19 of 54

| Division of | <u>of Health Service Regu</u> | lation | | | |
|---------------|-------------------------------|--|------------------|---|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED |
| | | | | | R-C |
| | | MHL049-123 | B. WING | | 06/28/2019 |
| | | | | | 1 00/20/2010 |
| NAME OF P | ROVIDER OR SUPPLIER | | DRESS, CITY, STA | | |
| HELMS H | OUSE | | BYTERIAN ROA | | |
| | | MOORES | VILLE, NC 2811 | 15 | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | |
| PREFIX TAG | • | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | |
| IAG | 1,2002 11 01 11 01 11 | , | IAG | DEFICIENCY) | |
| 1/ 400 | - · · · - | | 1,400 | | |
| V 133 | Continued From page | e 19 | V 133 | | |
| | (d) Limited Immunity. | - A provider and an officer | | | |
| | | vider that, in good faith, | | | |
| | | ction shall be immune from | | | |
| | civil liability for: | | | | |
| | (1) The failure of the | provider to employ an | | | |
| | | s of information provided in | | | |
| | | cord check of the individual. | | | |
| | (2) Failure to check a | n employee's history of | | | |
| | criminal offenses if the | e employee's criminal | | | |
| | | s requested and received in | | | |
| | compliance with this s | - | | | |
| | (e) Relevant Offense. | - As used in this section, | | | |
| | | ans a county, state, or | | | |
| | federal criminal histor | y of conviction or pending | | | |
| | indictment of a crime, | whether a misdemeanor or | | | |
| | felony, that bears upo | on an individual's fitness to | | | |
| | have responsibility for | r the safety and well-being of | | | |
| | persons needing men | ntal health, developmental | | | |
| | disabilities, or substar | nce abuse services. These | | | |
| | crimes include the cri | minal offenses set forth in | | | |
| | any of the following A | rticles of Chapter 14 of the | | | |
| | General Statutes: Arti | icle 5, Counterfeiting and | | | |
| | Issuing Monetary Sub | ostitutes; Article 5A, | | | |
| | | ve and Legislative Officers; | | | |
| | | article 7A, Rape and Other | | | |
| | | 8, Assaults; Article 10, | | | |
| | | ction; Article 13, Malicious | | | |
| | Injury or Damage by | • | | | |
| | _ | Material; Article 14, Burglary | | | |
| | | akings; Article 15, Arson and | | | |
| | _ | le 16, Larceny; Article 17, | | | |
| | | Embezzlement; Article 19, | | | |
| | False Pretenses and | | | | |
| | Obtaining Property or | - | | | |
| | | edit Device or Other Means; | | | |
| | | Transaction Card Crime | | | |
| | | s; Article 21, Forgery; Article | | | |
| | 26, Offenses Against | • | | | |
| | Decency: Article 26A | Adult Establishments: | 1 | 1 | 1 |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 20 of 54

| Division of | <u>of Health Service Regu</u> | lation | | | |
|-------------------|-------------------------------|---|-------------------|---|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED |
| | | | | | R-C |
| | | MHL049-123 | B. WING | | 06/28/2019 |
| | | WITE043-123 | | | 06/26/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE, ZIP CODE | |
| LIEI MC LI | OHEE | 611 PRE | SBYTERIAN ROA | AD | |
| HELMS HOUSE MOORE | | MOORES | SVILLE, NC 281 | 15 | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | N (X5) |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | |
| TAG | REGULATORY OR I | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | NATE DATE |
| | | | | , | |
| V 133 | Continued From page | 20 | V 133 | | |
| | Article 27 Prostitution | n; Article 28, Perjury; Article | | | |
| | | , Misconduct in Public | | | |
| | • • | enses Against the Public | | | |
| | | iots and Civil Disorders; | | | |
| | Article 39, Protection | | | | |
| | Protection of the Fam | | | | |
| | | le 60, Computer-Related | | | |
| | | also include possession or | | | |
| | | ion of the North Carolina | | | |
| | | s Act, Article 5 of Chapter | | | |
| | | tutes, and alcohol-related | | | |
| | offenses such as sale | to underage persons in | | | |
| | violation of G.S. 18B- | 302 or driving while | | | |
| | impaired in violation of | of G.S. 20-138.1 through | | | |
| | G.S. 20-138.5. | | | | |
| | | ing False Information Any | | | |
| | | nent who willfully furnishes, | | | |
| | | e gives false information on | | | |
| | | cation that is the basis for a | | | |
| | | d check under this section | | | |
| | shall be guilty of a Cla | | | | |
| | | yment A provider may | | | |
| | employ an applicant of | - · | | | |
| | • | of a criminal history record | | | |
| | check regarding the a | | | | |
| | following requirement | not employ an applicant | | | |
| | • • | applicant's consent for | | | |
| | criminal history record | | | | |
| | • | section or the completed | | | |
| | | equired in G.S. 114-19.10. | | | |
| | | submit the request for a | | | |
| | ` ' | d check not later than five | | | |
| | business days after th | | | | |
| | conditional employme | <u> </u> | | | |
| | | 124, ss. 10.19D(c), (h); | | | |
| | 2005-4, ss. 1, 2, 3, 4, | | | | |
| | , , _ , 3, . , | , | | | |
| | | | | | |

STATE FORM 6899 COUV11 If continuation sheet 21 of 54

| DIVISION | n nealth Service Regu | ialion | _ | | | |
|-------------------|----------------------------|--|------------------|--|-------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPL | ETED |
| | | | | | | |
| | | MIII 040 400 | B. WING | | R- | |
| | | MHL049-123 | 1 | | 1 06/2 | 8/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, STA | TE, ZIP CODE | | |
| | | 611 PRES | BYTERIAN RO | AD | | |
| HELMS H | OUSE | | VILLE, NC 281 | | | |
| | OUR MAR DV OT | | , | | | |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | • | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | | DATE |
| | | | | DEFICIENCY) | | |
| 1/ 122 | O | . 04 | V 133 | | | |
| V 133 | Continued From page | 21 | V 133 | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | This Rule is not met | as evidenced by: | | | | |
| | | ews and interviews, the | | | | |
| | | e a request for a criminal | | | | |
| | - | was completed within five | | | | |
| | business days of a co | | | | | |
| | - | 4 of 5 audited staff (staff | | | | |
| | . , | he facility also failed to | | | | |
| | T | a criminal history record | | | | |
| | • | ne applicant's fingerprints for | | | | |
| | | een a resident of this State | | | | |
| | | rs, was completed within five | | | | |
| | business days of a co | • | | | | |
| | _ | 1 of 5 audited staff (staff | | | | |
| | #3). The findings are | | | | | |
| | "o). The initiality of the | • | | | | |
| | Review on 6/27/19 of | staff #1's personnel record | | | | |
| | revealed: | otali ii i o poroonii ci recora | | | | |
| | -A hire date of 4/24/19 | Q· | | | | |
| | | at a request for a criminal | | | | |
| | history record check | • | | | | |
| | Thotory record check t | was completed. | | | | |
| | Review on 6/27/19 of | staff #2's personnel record | | | | |
| | revealed: | otali #20 porconiioi record | | | | |
| | -A hire date of 4/25/19 | g. | | | | |
| | | nal history record check was | | | | |
| | completed on 6/4/19. | iai mistery record check was | | | | |
| | completed on or ir io. | | | | | |
| | Review on 6/27/19 of | staff #3's personnel record | | | | |
| | revealed: | otali #0 5 personner record | | | | |
| | -A hire date of 4/16/19 | ٥٠ | | | | |
| | | ated the staff had resided in | | | | |
| | another state between | | | | | |
| | | at a request for a criminal | | | | |
| | | hat included the staff's | | | | |
| | _ | | | | | |
| | fingerprints was comp | neteu. | | | | |
| | Daviow on 6/27/40 - | staff #4's personnel record | | | | |
| | Review on 6/27/19 of | staff #4's personnel record | 1 | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 22 of 54

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---------------|---|--|------------------|---|-------------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED |
| | | | | | R-C |
| | | MHL049-123 | B. WING | | 06/28/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | |
| | | 611 PRES | BYTERIAN ROA | AD | |
| HELMS H | OUSE | MOORES | VILLE, NC 281 | 15 | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | DN (X5) |
| PREFIX TAG | , | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETE |
| V 133 | Continued From page | e 22 | V 133 | | |
| | revealed: | | | | |
| | -A hire date of 5/8/19 | | | | |
| | | , nat a request for a criminal | | | |
| | history record check | • | | | |
| | Thousand Todard and an | mad dempreted. | | | |
| | Review on 6/27/19 of | staff #5's personnel record | | | |
| | revealed: | | | | |
| | -A hire date of 5/1/19 | | | | |
| | | nal history record check was | | | |
| | completed on 6/4/19. | | | | |
| | Interview on 6/28/19 v | with the Qualified | | | |
| | Professional (QP) #1 | | | | |
| | ` ' | of weeks, it had been the | | | |
| | responsibility of the C | | | | |
| | ensure their personne | el files were complete prior | | | |
| | to beginning work; | | | | |
| | | lefense, she may not be | | | |
| | aware of what was ne | eeded (in personnel files)." | | | |
| | Interview on 6/27/19 | with the QP #2 revealed: | | | |
| | -She had not been inf | formed of what was required | | | |
| | to be in personnel file | s before staff began working | | | |
| | until approximately 2 | weeks ago; | | | |
| | -She had been going | through the personnel files | | | |
| | since that time to ens | ure they were complete. | | | |
| | Interview on 6/27/19 v | with the Operations Manager | | | |
| | | nere were issues in the past | | | |
| | | Is not being completed but | | | |
| | he thought they had g | | | | |
| | -"I thought I had farm | ed that (ensuring personnel | | | |
| | • | te before employees began | | | |
| | | (P #2) but I didn't make it | | | |
| | clear enough;" | | | | |
| | | - · | | | |
| | | | | | |
| | | | | | |
| | clear enough;" -It had been discovered that the QP #2 overse so they were now tak | ed during the past 2 weeks eeing hiring wasn't working ing a team approach and he 1 and #2 were working | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 23 of 54

| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|---|--|
| | | A. BOILDING. | | R-C | |
| | MHL049-123 | B. WING | | 06/28/2019 | |
| SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| | 611 PRES | BYTERIAN ROA | AD | | |
| | MOORES | VILLE, NC 2811 | 5 | | |
| CH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD | BE COMPLETE | |
| From page | 23 | V 133 | | | |
| o hire emplo are rushing get them s | oyees; g them (new employees) tarted." | | | | |
| ency is cros G .0201 Sco | ssed referenced into 10A ope (V293) for a Type B and | | | | |
| I Residentia | al Tx. Child/Adol - Scope | V 293 | | | |
| dential treat r adolescen ling residen active thera ons within a be the prima a client of secure meal ring client si continuous a on. opulation se rest who have ess, emotic related dis ng disorder a. These ch criteria for in hildren or ac e following: removal froi y-based res reatment; a treatment in | treat staff secure facility for the is one that is a stial facility that provides apeutic treatment and system of care approach. It may residence of an individual the facility. In staff are required to be deep hours and supervision is set forth in Rule .1704 of the extraction of the individual states and supervision is set forth in Rule .1704 of the extraction of the individual states and may also have including developmental states and may also have including developmental states and individual setting in order to a staff secure setting. | | | | |
| | I From page of hire employage them seems within a continuous a continu | MHL049-123 SUPPLIER STREET AD 611 PRES MOORES' SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) I From page 23 In hire employees; are rushing them (new employees) get them started." Sency constitutes a re-cited deficiency. Sency is crossed referenced into 10 A COCOL Scope (V293) for a Type B and corrected within 45 days. I Residential Tx. Child/Adol - Scope COCOL 27G .1701 SCOPE COCOL 3701 S | MHL049-123 SUPPLIER STREET ADDRESS, CITY, STA 611 PRESBYTERIAN RO/ MOORESVILLE, NC 2811 SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) I From page 23 O hire employees; are rushing them (new employees) of ethem started." lency constitutes a re-cited deficiency. dency is crossed referenced into 10 A G .0201 Scope (V293) for a Type B and orrected within 45 days. I Residential Tx. Child/Adol - Scope C 27G .1701 SCOPE dential treatment staff secure facility for radolescents is one that is a ing residential facility that provides active therapeutic treatment and ons within a system of care approach. It extense the primary residence of an individual racilient of the facility. Secure means staff are required to be ring client sleep hours and supervision continuous as set forth in Rule .1704 of one. Depulation served shall be children or one the who have a primary diagnosis of ease, emotional disturbance or expelated disorders; and may also have no disorders including developmental and the start of inpatient psychiatric services. Indidence or adolescents shall criteria for inpatient psychiatric services. Indidence or adolescents served shall be following: removal from home to a y-based residential setting in order to reatment; and treatment; and treatment in a staff secure setting. The service of the facility of t | MHL049-123 STREET ADDRESS, CITY, STATE, ZIP CODE 611 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 SUMMARY STATEMENT OF DEFICIENCIES CHOPENCIENCY MUST BE PRECEDED BY FULL CHATCRY OR LSC IDENTIFYING INFORMATION) IF From page 23 In hire employees; are rushing them (new employees) riget them started." ency is crossed referenced into 10 A 3 (2021 Scope (V293) for a Type B and corrected within 45 days. I Residential Tx. Child/Adol - Scope C 27G .1701 SCOPE dential treatment staff secure facility for radolescents is one that is a inig residential facility that provides active therapeutic treatment and nos within a system of care approach. It we the primary residence of an individual at a client of the facility. Recure means staff are required to be fing client sleep hours and supervision nontinuous as set forth in Rule .1704 of sin. Opulation served shall be children or its who have a primary diagnosis of ess, emotional disturbance or erelated disorders; and may also have ng disorders including developmental is. These children or adolescents shall criteria for inpatient psychiatric services. Indiden or adolescents served shall endowing its momentum of the residential setting in order to reatment; and treatment in a staff secure setting, ses shall be designed to: | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 24 of 54

Division of Health Service Regulation

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--|---|-------------------------------|------|
| | | MHL049-123 | B. WING | | R-C 06/28/2019 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | RESS, CITY, STA | TE, ZIP CODE | 1 00/20/2013 | |
| HELMS H | OUSE | | SYTERIAN ROA ILLE, NC 2811 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPL | LETE |
| V 293 | related to functional d (3) ensure safe control behaviors incl management with or (4) assist the cl acquisition of adaptive communication, socia (5) support the gaining the skills need intensive treatment set (f) The residential treshall coordinate with the control of the con | g; e occurrence of behaviors leficits; ty and deescalate out of uding frequent crisis without physical restraint; hild or adolescent in the e functioning in self-control, al and recreational skills; and child or adolescent in ded to step-down to a less etting. latment staff secure facility | V 293 | | | |
| | facility failed to provid therapeutic treatment scope of residential s continuous supervision | ews and interviews, the | | | | |
| | Personnel Requiremer record reviews and in ensure a complete pe | E: 10A NCAC 27G .0202 ents (V107). Based on terviews, the facility failed to ersonnel file was maintained f (staff #1, #2, #3, and #4). | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 25 of 54

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE C | СОМ | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|--|-----------------------------------|--------------------------|
| | | MHL049-123 | B. WING | | | R-C 6/ 28/2019 |
| NAME OF PROV | DER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | , ZIP CODE | | |
| HELMS HOUS | SE . | | SBYTERIAN ROAD | | | |
| | 0.114.44.70.4.6 | | SVILLE, NC 28115 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| CF Per ren #44 ann bala clii (st CF As Ser ren im aff CF Mer ren mer #2 CF Ca ren (H au CF Hi. Ap ren | ersonnel Requirent cord reviews and sure 4 of 5 audited) had completed right of failed to ensure sic first aid was a ents were present aff #1, #2, #3, #4, ROSS REFERENT cord reviews, the electron of 4 client ROSS REFERENT cord review and insure 1 of 5 audited edication training pedications affecting 1, #3, and #4). ROSS REFERENT cord review and insure 1 of 5 audited edications affecting and training pedications affecting the Health Cord review and interviews and int | CE: 10A NCAC 27G .0202 nents (V108). Based on interviews, the facility failed to d staff (staff #1, #2, #3, and minimum employee training at least 1 employee trained in vailable in the facility while d affecting 5 of 5 audited staff and #5). CE: 10A NCAC 27G .0205 eatment/Habilitation or D. Based on interviews and facility failed to develop and reflect the needs of the clients | V 293 | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 26 of 54

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|--|-------------------------------|--|
| | | | A. BUILDING: _ | | | |
| | | MHL049-123 | B. WING | | R-C 06/28/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, STA | TE, ZIP CODE | | |
| HELMS H | OUSE | | BYTERIAN ROA ILLE, NC 281 | | | |
| | CHMMADY CT | | · · | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE | |
| V 293 | Continued From page | e 26 | V 293 | | | |
| | also failed to ensure a history record check t fingerprints for applica resident of this State completed within five | a request for a criminal that included the applicant's ant's that had been a for less than five years, was business days of a apployment affecting 1 of 5 | | | | |
| | Minimum Staffing Red on record reviews and body failed to ensure members were presen | E: 10A NCAC 27G .1704 quirements (V296). Based d interviews, the governing at least two direct care staff nt with every four children or 3 of 4 surveyed clients 3). | | | | |
| | Incident Response Reand B Providers (V36 | E: 10A NCAC 27G .0603 equirements for Category A 6). Based on record review sility failed to document their cidents. | | | | |
| | Training on Alternative Interventions (V536). and interview, the factories trained in alternative trained alt | Based on record reviews ility failed to ensure staff atives to restrictive I basis affecting 2 of 5 | | | | |
| | Training in Seclusion, Isolation Time-Out (V reviews and interview staff were trained in s | E: 10A NCAC 27E .0108 Physical Restraint and 537). Based on record the facility failed to ensure eclusion, physical restraint affecting 2 of 5 audited staff | | | | |
| | | E: 10A NCAC 27G .0304 guipment (V744). Based on | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 27 of 54

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY |
|--------------------------|--|--|---------------------|---|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED |
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| | | MHL049-123 | B. WING | | 06/28/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, STA | TE, ZIP CODE | |
| | 21105 | 611 PRES | BYTERIAN ROA | AD | |
| HELMS H | JUSE | MOORES\ | /ILLE, NC 2811 | 15 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE |
| V 293 | Continued From page | 27 | V 293 | | |
| | ensure the facility was | views, the facility failed to s equipped in a manner that safety of clients, staff and | | | |
| | Review on 6/28/19 of the Plan of Protection written and dated 6/28/19 by the Operations Manager revealed: "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? | | | | |
| | | | | | |
| | will be notified of pers | nnel file requirements, staff sonal information that needs em to be placed in their | | | |
| | employee file. They w | vill be given 7 days to | | | |
| | present information o schedule. | r be removed from the | | | |
| | -Moving forward, no shomes until the entire | staff shall be permitted in the | | | |
| | requirements (other the | nan tabs 3, 7, and 8) have | | | |
| | | ir files and appropriate ut in place. With regard to | | | |
| | CPR (cardiopulmonal | ry resuscitation)/1st | | | |
| | | istration training, these ithin the employee's first 90 | | | |
| | | Until these trainings are well Development Center | | | |
| | policy that at least on have current CPR/1st | e person on shift MUST t Aid/Medication | | | |
| | Administration certification -Fire Extinguishers sh | ation. nall be taken to have them | | | |
| | recharged and certifie | ed for 2019 use. | | | |
| | | ns made to treatment plans | | | |
| | | ansported with only one xplanation of why such | | | |
| | coverage is applicable and which occasions | e/appropriate for that client, shall be appropriate for | | | |
| | | on shall be presented to inimum of 72 hours prior to | | | |

Division of Health Service Regulation

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Division of Health Service Regulation

| DIVISION | of Health Service Regu | lation | | | | |
|-------------------|---|--|------------------|--|--------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SU | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLET | TED |
| | | | | | R-C | |
| | | MUL 040 422 | B. WING | | 1 | , s/2019 |
| | | MHL049-123 | | | 06/28 | 72019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, STA | TE, ZIP CODE | | |
| | | 611 PRES | BYTERIAN RO | AD | | |
| HELMS H | OUSE | | VILLE, NC 281 | | | |
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| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
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| | | | | DEFICIENCY) | | |
| 1/ 000 | 0 " 15 | 00 | 1/ 000 | | | |
| V 293 | Continued From page | 28 | V 293 | | | |
| | admission. During that | at time there shall be | | | | |
| | | s made to house staff | | | | |
| | detailing diagnosis, hi | | | | | |
| | | ial precautions that may | | | | |
| | need to be put in place | | | | | |
| | l · · · · · · · · · · · · · · · · · · · | staff feedback should they | | | | |
| | | ggestions. During this 72 | | | | |
| | I | d Professional) will discuss | | | | |
| | with house manager | * | | | | |
| | _ | es/plans that might/will be | | | | |
| | | re all known client behaviors | | | | |
| | • | o admittance to the facility | | | | |
| | - | o plan for best possible | | | | |
| | client outcomes. | o plan for best possible | | | | |
| | | has been recently changed | | | | |
| | | s must be completed prior to | | | | |
| | • | nd be reflected in service | | | | |
| | | es. All reports must be | | | | |
| | emailed (prior to end | | | | | |
| | T | ls.com, which includes the | | | | |
| | owner, Ops (Operation | | | | | |
| | | ed Professionals and office | | | | |
| | administrator. | ed i Totessionais and Office | | | | |
| | | o make sure the above | | | | |
| | happens. | o make sure the above | | | | |
| | | and QP's will meet every | | | | |
| | | eview files, ascertain what | | | | |
| | , , | are missing, and take | | | | |
| | | ther placing newly acquired | | | | |
| | information in person | | | | | |
| | | personnel of outstanding | | | | |
| | necessary information | • | | | | |
| | _ | tive list by removing them | | | | |
| | from the schedule). | ave not by removing them | | | | |
| | -Moving forward, new | hires shall have files | | | | |
| | _ | rking shifts, and then all files | | | | |
| | | _ | | | | |
| | | nthly to ensure all training | | | | |
| | | re in place. QP's shall be | | | | |
| | subject to disciplinary | | | | | |
| | employee with a fire | date after 6/28/19 be found | I | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 29 of 54

Division of Health Service Regulation

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | | | E SURVEY PLETED |
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| | | MHL049-123 | B. WING | | I | R-C 6/ 28/2019 |
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| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | E, ZIP CODE | | |
| HELMS H | OUSE | 611 PRE | SBYTERIAN ROAI | D | | |
| | 0002 | MOORES | SVILLE, NC 28115 | 5 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| V 293 | Continued From page | e 29 | V 293 | | | |
| | to be working shifts w personnel file." | vithout a 100% compliant | | | | |
| | Interview on 6/28/19 revealed: | with the Operations Manager | | | | |
| | -He had reviewed the QP's and they all thin | Plan of Protection with both k it is realistic; | | | | |
| | -The QP's were conc demand capacity man | erned that the Owner would ndates and the QP's | | | | |
| | wouldn't be provided | sufficient time to educate | | | | |
| | the staff prior to client facility. | ts being admitted to the | | | | |
| | secure facility which por adolescents whose mental illness, emotic substance-related disclients residing in the including Post Traum Attention Deficit Hype Depressive Disorder, Dysregulation Disorder, Dysregulation Disorder, Disorder, Disorder, Dysregulation Disorder, D | facility with diagnoses atic Stress Disorder, Major Disruptive Mood er, acid reflux, multiple ory of physical and sexual documentation that three d job descriptions. There n for four Paraprofessionals | | | | |
| | the mh/dd/sa needs o | completed training to meet of clients. There was no | | | | |
| | completed basic first | Paraprofessionals had aid training. According to the | | | | |
| | June 2019 staff scheen which there was no si | dule, there were 6 shifts in taff available that had | | | | |
| | completed basic first documentation that the | aid training. There was no ne Health Care Personnel | | | | |
| | | or to hiring. There was no | | | | |
| | | riminal record request for 5 thin 5 business days of | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 30 of 54

| Division of | of Health Service Regu | lation | | | | |
|--------------------------|---|--|----------------------------|---|----------------------|-------------|
| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | (X3) DATE S COMPL | |
| мн | | MHL049-123 | B. WING | | R- 06/2 | C 8/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STAT | E, ZIP CODE | | |
| UEL MO U | 01105 | 611 PRE | SBYTERIAN ROA | ND. | | |
| HELMS H | OUSE | MOORES | SVILLE, NC 2811 | 5 | | |
| (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | ON SHOULD BE CO | |
| V 293 | Continued From page | e 30 | V 293 | | | |
| | of the Paraprofession within the past 5 year request should have a check for that staff. T that one Paraprofessi medication administra administering medical Paraprofessionals ha alternatives to restrict in seclusion, physical time-out prior to provi Goals to address clie of multiple personaliti were not developed a not aware that there is clients unless clients it was documented in that based on their st could be transported failed to arrive to workshift workers left the formation of the past | ation training prior to | | | | |

Division of Health Service Regulation

member failed to notify anyone that she was working by herself and fell asleep while working. While the staff was sleeping, a client obtained the facility keys, unlocked the medication closet, obtained a pair of scissors and cut her hair off. An incident report for the incident was not completed in a timely manner. The cumulative effect of the Licensee's failures to maintain staff records, arrange training, develop and implement goals based on client needs, provide for client supervision, complete incident reports timely, maintain fire extinguisher or ensure client safety via personnel checks is detrimental to the health, safety and welfare of the client. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of \$200.00 per day will be imposed for

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| DIVISION OF FEBRUARIES | | | | | \neg | |
|------------------------|--------------------------|--|-------------------|---------------------------------|------------------|----|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED | |
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| | | MHL049-123 | B. WING | | 06/28/2019 | |
| | | WII 12043-123 | | | 00/20/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE, ZIP CODE | | |
| | | 611 PRE | SBYTERIAN RO | AD | | |
| HELMS H | DUSE | MOORES | SVILLE, NC 281 | 15 | | |
| ()(4) ID | SLIMMADV ST | ATEMENT OF DEFICIENCIES | · ID | PROVIDER'S PLAN OF CORRECTION | J (VE) | |
| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOULD | (/ | TE |
| TAG | REGULATORY OR I | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPE | RIATE DATE | |
| | | | | DEFICIENCY) | | |
| V 293 | Continued From page | 31 | V 293 | | | |
| . 200 | Continued From page | 201 | * 200 | | | |
| | each day the facility is | s out of compliance beyond | | | | |
| | the 45th day. | | | | | |
| | | | | | | |
| V 296 | 27G .1704 Residentia | al Tx. Child/Adol - Min. | V 296 | | | |
| | Staffing | | | | | |
| | 3 | | | | | |
| | 10A NCAC 27G .1704 | 4 MINIMUM STAFFING | | | | |
| | REQUIREMENTS | | | | | |
| | (a) A qualified profes | sional shall be available by | | | | |
| | | A direct care staff shall be | | | | |
| | | lity within 30 minutes at all | | | | |
| | times. | • | | | | |
| | (b) The minimum nur | mber of direct care staff | | | | |
| | required when childre | en or adolescents are | | | | |
| | present and awake is | as follows: | | | | |
| | (1) two direct c | are staff shall be present for | | | | |
| | one, two, three or fou | r children or adolescents; | | | | |
| | (2) three direct | care staff shall be present | | | | |
| | for five, six, seven or | eight children or | | | | |
| | adolescents; and | | | | | |
| | (3) four direct of | care staff shall be present for | | | | |
| | nine, ten, eleven or tv | velve children or | | | | |
| | adolescents. | | | | | |
| | . , | mber of direct care staff | | | | |
| | | scent sleep hours is as | | | | |
| | follows: | | | | | |
| | ` ' | are staff shall be present | | | | |
| | | ke for one through four | | | | |
| | children or adolescen | • | | | | |
| | | are staff shall be present | | | | |
| | | ake for five through eight | | | | |
| | children or adolescen | | | | | |
| | | care staff shall be present awake and the third may be | | | | |
| | | | | | | |
| | asieep for nine, ten, e | eleven or twelve children or | | | | |
| | | minimum number of direct | | | | |
| | . , | Paragraphs (a)-(c) of this | | | | |
| | | | | | | |
| | Rule, more direct care | e staff shall be required in | 1 | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 32 of 54

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|--|--------------------------|
| | | | A. BUILDING: _ | | |
| | | MHL049-123 | B. WING | | R-C 06/28/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, STA | TE, ZIP CODE | |
| LIEL MO LI | 01105 | 611 PRES | BYTERIAN RO | AD | |
| HELMS H | UUSE | MOORES\ | /ILLE, NC 281 | 15 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE |
| V 296 | Continued From page the facility based on t | e 32 he child or adolescent's | V 296 | | |
| | individual needs as sp plan. | pecified in the treatment | | | |
| | supervision of childre | be responsible for ensuring n or adolescents when they | | | |
| | | cility in accordance with the individual strengths and the treatment plan. | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | This Rule is not met | as evidenced by: ews and interviews, the | | | |
| | governing body failed | to ensure at least two direct ere present with every four | | | |
| | children or adolescen | ts affecting 3 of 4 clients | | | |
| | (Clients #1, #2, and # | 3). The findings are: | | | |
| | -An age of 12 years o | | | | |
| | -An admission date of -Diagnoses included l | r 3/8/19; Post Traumatic Stress | | | |
| | I | ention Deficit Hyperactivity essive Disorder, a history of | | | |
| | physical and sexual a personalities; | | | | |
| | | inical Assessment dated | | | |
| | | elieved to have experienced | | | |
| | • • | buse from her step-father the abuse of other children | | | |
| | in the home, and her abuse;" | mother was aware of the | | | |
| | -"She has difficul | ty respecting boundaries | | | |
| | within a home setting | , and will take things that do | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 33 of 54

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HELMS HOUSE A. BUILDING: R-C 06/28/2019 | | N OF CORRECTION | IDENTIFICATION NUMBER: | (X2) MULTIPLE | | (X3) DATE SURVEY COMPLETED | |
|--|------------|--|--|-----------------|--|-------------------------------|----------------------|
| MHL049-123 B. WING | | | | A. BUILDING | | | |
| HELMS HOUSE 611 PRESBYTERIAN ROAD | | | MHL049-123 | B. WING | | | 9 |
| HELMS HOUSE | NAME OF PR | PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| | HELMS HO | HOUSE | 611 PRESE | BYTERIAN ROA | AD. | | |
| MOORESVILLE, NC 28115 | | | MOORESV | ILLE, NC 2811 | 15 | | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP | PREFIX | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI | BE COM | X5) IPLETE ATE |
| V 296 Continued From page 33 V 296 | V 296 | 6 Continued From page | e 33 | V 296 | | | |
| "in one placement she was found on top of another child who was sleeping." -A Comprehensive Clinical Assessment Addendum dated 1/10/19 included: -"[Client #1] will continue to touch her peers without asking, and will make sexualized comments." -"[Client #1] has written about and drawn pictures about sexualized behaviors, which included drawing pictures of penises and asking peers if they want to have sex with her," -A Treatment Plan dated 2/27/19 included: -"[Client #1] was admitted to [a local hospital] on 7/13/18 due to increasing command auditory and visual hallucinations telling her to kill her foster mother," -"[Client #1] also had started displaying increasing sexualized behaviors, which included frequent masturbation," -"[Client #1] has a history of being sexually and physically abused by her stepfather," -"Since then, [client #1] has exhibited symptoms including sexually acting out, watching pornography, and touching animals inappropriately;" -No documentation indicating that based on the client's strengths and needs she was able to be transported by one staff. Review on 6/27/19 of client #2's record revealed: -An age of 15 years old; -An admission date of 3/25/19; -Diagnoses included PTSD, Disruptive Mood Dysregulation Disorder (DMDD) and acid reflux; -A Treatment Plan dated 2/26/19 revealed no documentation that indicated based on the client's strengths and needs she was able to be transported by one staff. | | -"in one placer another child who wa -A Comprehensive C Addendum dated 1/1 -"[Client #1] will owithout asking, and wo comments;" -"[Client #1] has pictures about sexual included drawing pict peers if they want to -A Treatment Plan da -"[Client #1] was on 7/13/18 due to incomment and visual hallucination foster mother;" -"[Client #1] also increasing sexualized frequent masturbation -"[Client #1] has and physically abuse -"Since then, [client symptoms including spornography, and too inappropriately;" -No documentation the client's strengths be transported by one Review on 6/27/19 of -An age of 15 years of -An admission date of -Diagnoses included Dysregulation Disord -A Treatment Plan dadocumentation that in client's strengths and | ment she was found on top of as sleeping;" clinical Assessment 0/19 included: continue to touch her peers will make sexualized written about and drawn clized behaviors, which tures of penises and asking have sex with her;" ated 2/27/19 included: admitted to [a local hospital] creasing command auditory ions telling her to kill her had started displaying d behaviors, which included n;" a history of being sexually d by her stepfather;" eent #1] has exhibited sexually acting out, watching uching animals ion indicating that based on and needs she was able to e staff. f client #2's record revealed: old; of 3/25/19; PTSD, Disruptive Mood ler (DMDD) and acid reflux; ated 2/26/19 revealed no indicated based on the d needs she was able to be | V 296 | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 34 of 54

| DIVISION | i Health Service Regu | ı | | | 1 |
|-------------------|------------------------|--|-------------------|---|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED |
| | | | | | R-C |
| | | MUI 040 422 | B. WING | | |
| | | MHL049-123 | | | 06/28/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE, ZIP CODE | |
| | | 611 PRE | SBYTERIAN RO | AD | |
| HELMS H | OUSE | | SVILLE, NC 281 | | |
| | OLIMANA DV OT | | | | ., |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD | |
| TAG | , | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROP | |
| | | | | DEFICIENCY) | |
| V 296 | Continued From page | 24 | V 296 | | |
| V 290 | Continued From page | : 34 | V 290 | | |
| | -An age of 13 years of | old; | | | |
| | -An admission date of | f 6/18/19; | | | |
| | -Diagnoses included | DMDD and a history of | | | |
| | sexual abuse; | | | | |
| | -A Comprehensive CI | linical Summary dated | | | |
| | 5/23/19 revealed"m | ood symptoms began | | | |
| | around the age of 10 | and [client #3's] behaviors | | | |
| | _ | sion at home and at school, | | | |
| | AWOL (absent withou | | | | |
| | • | ce, and meeting up with | | | |
| | | ially have sex with them;" | | | |
| | • | ted 5/23/19 revealed no | | | |
| | documentation that in | ndicated based on the | | | |
| | client's strengths and | needs she was able to be | | | |
| | transported by one st | | | | |
| | | | | | |
| | Finding #1: Clients we | ere being transported by 1 | | | |
| | staff. | | | | |
| | | | | | |
| | Interviews on 6/27/19 | with clients #2 and #3 | | | |
| | revealed: | | | | |
| | -They had been trans | ported by themselves and | | | |
| | with 1 other client by | 1 staff; | | | |
| | -Staff had informed th | nem they were required to | | | |
| | have 1 staff for every | • | | | |
| | · | | | | |
| | Interview on 6/28/19 | with staff #1 revealed: | | | |
| | -She thought that the | staff to client ratio was | | | |
| | always 1 staff for eve | ry 2 clients; | | | |
| | _ | usually on restriction and | | | |
| | | on outings so 1 staff stayed | | | |
| | • | t client and the other staff | | | |
| | transported the rest o | | | | |
| | - p | | | | |
| | Interview on 6/28/19 | with staff #2 revealed: | | | |
| | | staff to client ratio was | | | |
| | always 1 staff for eve | | | | |
| | _ | on 1st and 2nd shifts had | | | |
| | | 1 or 2 clients with 1 staff. | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 35 of 54

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | E SURVEY PLETED | |
|---|--|---|---------------------|--|-----------------------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | MHL049-123 | B. WING | | | R-C 6/28/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | , ZIP CODE | | |
| UEI MO U | OUSE | 611 PRE | SBYTERIAN ROAD | 1 | | |
| HELMS H | OUSE | MOORES | SVILLE, NC 28115 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 296 | Continued From page | e 35 | V 296 | | | |
| | -She had always tran staff; -She thought the only transport clients was Interview on 6/28/19 -She thought the staf staff for 2 clients; -"One staff is never a clients." Interview on 6/28/19 Professional (QP) #1 -She usually complet Plans; -She was not aware t documentation that ir client's strengths and | revealed: ed the client Treatment | | | | |
| | -"An appointment wo one staff would trans -She was not aware t documentation that ir client's strengths and transported by one st transported by 1 staff Interview on 6/28/19 revealed: -He was aware that 2 transport clients unleincluded in the clients indicated based on the | with the Qualified aled: 2 staff transport clients;" uld probably be the only time port a client;" here needed to be indicated based on the needs they were able to be aff prior to the clients being | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 36 of 54

PRINTED: 07/12/2019 FORM APPROVED

Division of Health Service Regulation

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|---------------------|--|-------------------------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED |
| | | MHL049-123 | B. WING | | R-C 06/28/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, STA | TE, ZIP CODE | |
| HELMS H | OUSE | 611 PRESI | BYTERIAN ROA | AD | |
| | | MOORES | /ILLE, NC 2811 | 5 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETE |
| V 296 | Continued From page | e 36 | V 296 | | |
| | staff; -Treatment Plans well QP #1; -"That (the QP not up was just a miscommular properties) Finding #2: One staff 3rd shift failed to arrive from 2nd shift left. The scheduled to work 3rd that she was working during the shift allowing the s | re usually completed by the dating the Treatment Plans) unication on my part." member scheduled to work we to work and both the staff we other staff member d shift failed to notify anyone by herself and fell asleep ng client #1 to obtain the in closet where the scissors | | | |
| | revealed: -She had received a cher that the client had -The staff that called working when the incaccording to her the and closed their eyes cut her hair before she "She (client #1) show with scissors;" -She had been inform hospital that the clien the hospital because during group on 6/11/2 heaven; | "staff said I turned my back for a minute" and the client ee turned back around; uldn't have been left alone | | | |
| | Review on 6/28/19 of completed by staff #7 -Type of incident: sha -Date/Time of inciden -Date Form Complete -"In the middle of the | revealed: aved head; at: 6/23/19/3:00am; | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 37 of 54

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---------------|--|--|-----------------|--|-------------------------------|
| 711012111 | or connection | ibertii io, tiioit io mbert | A. BUILDING: _ | | JOHN ELTES |
| | | MHL049-123 | B. WING | | R-C 06/28/2019 |
| NAME OF D | ROVIDER OR SUPPLIER | | RESS, CITY, STA | TE ZIR CODE | 1 00/20/2013 |
| NAIVIE OF FI | ROVIDER OR SUFFLIER | | YTERIAN ROA | | |
| HELMS H | OUSE | | ILLE, NC 2811 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | V (X5) |
| PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE |
| V 296 | Continued From page | e 37 | V 296 | | |
| V 296 | left her room and tool let herself in the office scissors;" -"Client (#1) then cut boy;" -"Client (#1) then hide Interview on 6/28/19 she had worked 2nd #5 the night the incide occurred; -Client #2 had refused been in and out of he-Former staff (FS) #1 work 3rd shift from 11-At 11:45pm, FS #1 a work; -She called FS #2 and had just woken up and as soon as possible; -At 12:00am, FS #1 a #5 left the facility; -She was taught by the working and the staff with didn't arrive, she staff and then call the arrived within 30 minustraff were told at the they were to stay at the both staff from the ne leaving 1 staff by ther Interview on 6/28/19 she had worked 1st the morning after the occurred; | the keys for the house and and med closet and got the her hair and dress like a the keys and went to bed." with staff #2 revealed: shift on 6/22/19 with staff ent with client #1 had d to go to sleep and had room the entire evening; and #2 were scheduled to:30pm - 7:30am; nd #2 had not arrived to d she informed staff #2 she d would arrive at the facility wrived and both staff #2 and the QP #2 if she were she was scheduled to work was to attempt to call the QP #2 if the staff hadn't utes of the start of their shift; last staff meeting (6/27/19) the facility if possible until xt shift arrived rather than | V 296 | | |
| | #1 was the only staff -FS #1 informed the 1 | present; Ist shift staff that she didn't | | | |
| | know where the facilit | ty keys were and insinuated | I | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 38 of 54

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SU | |
|--------------------------|---|---|---------------------|---|--------------|--------------------------|
| | | | A. BOILDING | | R-(| _ |
| | | MHL049-123 | B. WING | | 1 | 8/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| HELMS H | OUSE | 611 PRES | BYTERIAN ROA | AD | | |
| | | | VILLE, NC 2811 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| V 296 | Continued From page | e 38 | V 296 | | | |
| V 296 | that 2nd shift hadn't g-According to FS #1, down all night and ha-FS #1 had observed hoodie right before 1s realized the client had-After FS #1 left the fa getting ready for the client had-After FS #1 left the fa getting ready for the client had she asked for them. Interview on 6/28/19 Manager/Associate Prevealed: -FS #1 and #2 were son the evening of 6/22-FS #1 was scheduled at work and FS #2 was and never arrived at v-FS #1 failed to notify arrive at work; -Both staff working 2r that there were 2 staff-FS #1 fell asleep and keys off the kitchen co-Client #1 used the ke closet door where the hair and then hid the Interview on 6/28/19 v-Client #1 informed he she cut her hair; -"We helped her make | client #1 had been up and d been wearing a hoodie; client #1 not wearing a st shift staff arrived and d cut her hair off; acility and the clients were day, she observed client #1 scissors; ssors from the client; cility keys to staff #3 when with the House rofessional (HM/AP) scheduled to work 3rd shift 2/19; d as awake staff and arrived as scheduled as sleep staff work; the HM/AP that FS #2 didn't and shift left prior to ensuring f at the facility; d client #1 took the facility ounter; eys to unlock the medication a scissors were kept, cut her | V 296 | | | |
| | | tutes a re-cited deficiency on 10/11/16, 4/10/17, and | | | | |

2/15/19.

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 39 of 54

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | |
|--------------------------|--|--|---------------------|---|-------------|--------------------------|
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLE | ETED |
| | | | | | R- | С |
| | | MHL049-123 | B. WING | | 06/2 | 8/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HELMS H | OHEE | 611 PRESB | YTERIAN ROA | AD | | |
| HELING H | JU3E | MOORESV | ILLE, NC 2811 | 5 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| V 296 | Continued From page | e 39 | V 296 | | | |
| | _ | ssed referenced into 10A ope (V293) for a Type B and hin 45 days. | | | | |
| V 366 | 27G .0603 Incident R | esponse Requirments | V 366 | | | |
| | implement written pol response to level I, II shall require the provi (1) attending to of individuals involved (2) determining (3) developing measures according timeframes not to exc (4) developing to prevent similar inci specified timeframes (5) assigning pofor implementation of preventive measures; (6) adhering to set forth in G.S. 75, A. | REMENTS FOR B PROVIDERS B providers shall develop and icies governing their or III incidents. The policies ider to respond by: The health and safety needs in the incident; The cause of the incident; The cause o | | | | |
| | 164; and (7) maintaining Subparagraphs (a)(1) (b) In addition to the Paragraph (a) of this shall address incident regulations in 42 CFF (c) In addition to the Paragraph (a) of this | documentation regarding through (a)(6) of this Rule. requirements set forth in Rule, ICF/MR providers ts as required by the federal R Part 483 Subpart I. requirements set forth in Rule, Category A and B CF/MR providers, shall | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 40 of 54

| MHL049-123 NAME OF PROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | CONSTRUCTION | (X3) DATE SI | |
|--|--------------|--|--|------------------|--|--------------|----------|
| MAIL OF PROVIDER OR SUPPLIER MAIL OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCES 611 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 V 366 CONTINUED (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION) V 366 Continued From page 40 develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the colent record; (3) making a photocopy; (1) immediately securing the client record; (3) making a photocopy; (2) convening a meeting of an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and | AIND PLAIN (| O CORRECTION | IDENTIFICATION NUMBER. | A. BUILDING: _ | | COMPLE | בובט |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 611 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 (A) ID PREPRIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SEP PRECEDED BY FULL TAG V 366 Continued From page 40 develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider to respond by: (T) immediately securing the client record by: (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall consplet all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and | | | | D WING | | 1 | |
| CALL DESTRICT CALL CAL | | | MHL049-123 | B. WING | | 06/2 | 8/2019 |
| CALLE DEFICIENCY MUST BE PRECIDED BY FULL PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DMTE | NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| (A) D RECIPION (B) SUMMARY STATEMENT OF DEFICIENCIES) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH OFFICIENCY AND INCOMPLIATE BY TAG) V 366 Continued From page 40 develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team within 24 hours of the incident. The internal review team within 24 hours of the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and | HEI MS H | OUSE | 611 PRES | BYTERIAN ROA | AD | | |
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| owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the | V 366 | develop and implement their response to a lew while the provider is corn while the client is corn while the corn while th | ant written policies governing wel III incident that occurs delivering a billable service on the provider's premises. Unite the provider to respond a securing the client record expected by the client record; notocopy; are copy's completeness; and the copy to an internal expected by the incident. The shall consist of individuals do in the incident and who for the client's direct care or all oversight of the client's fithe incident. The internal expected by the incident and who for the client's direct care or all oversight of the client's fithe incident. The internal expected by the incidents; are information needed; and preliminary findings of fact the incident. The fact shall be sent to the ment area the provider is the where the client resides, written report signed by the conths of the incident. The ent to the LME in whose | V 366 | | | |

Division of Health Service Regulation

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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPL | .ETED |
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| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
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| | | uments pertinent to the | | | | |
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| | · · · · · · · · · · · · · · · · · · · | ake recommendations for | | | | |
| | _ | ence of future incidents. If | | | | |
| | | d for the report are not | | | | |
| | | months of the incident, the | | | | |
| | | ovider an extension of up to | | | | |
| | | nit the final report; and | | | | |
| | | notifying the following: | | | | |
| | (A) the LME res | sponsible for the catchment | | | | |
| | area where the service | ces are provided pursuant to | | | | |
| | Rule .0604; | | | | | |
| | (B) the LME wh | nere the client resides, if | | | | |
| | different; | , | | | | |
| | · · | r agency with responsibility | | | | |
| | for maintaining and u | | | | | |
| | | erent from the reporting | | | | |
| | · · | creme from the reporting | | | | |
| | provider; | t. | | | | |
| | (D) the Departm | | | | | |
| | | legal guardian, as | | | | |
| | applicable; and | | | | | |
| | (F) any other a | uthorities required by law. | | | | |
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| | This Rule is not met | as evidenced by: | | | | |
| | | ew and interviews the facility | | | | |
| | | eir response to level 1 | | | | |
| | incidents. The finding | | | | | |
| | i incluento. The illiant | ys aic. | | | | |
| | Davious on 0/00/40 - | Incident Depart Farmer Lavel | | | | |
| | | Incident Report Form: Level | | | | |
| | 1 revealed: | | | | | |
| | -Type of Incident: Sha | | | | | |
| | -Date/Time of Inciden | | | | | |
| | -"In the middle of the | night client (#1) got bored, | | | | |
| | left her room and tool | k the keys for the house and | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 42 of 54

| STATEMENT OF DEPICIENCIES MD PLAN OF CORRECTION MHL049-123 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 611 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 PRITTY MELLIAN HOUSE SUMMARY STATEMENT OF DEPICIENCES 611 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 PRITTY MELLIAN HOUSE SUMMARY STATEMENT OF DEPICIENCES 611 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 PRITTY MELLIAN HOUSE SUMMARY STATEMENT OF DEPICIENCES 612 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 PRITTY MELLIAN HOUSE SUMMARY STATEMENT OF DEPICIENCES 613 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 PRITTY MELLIAN HOUSE SUMMARY STATEMENT OF DEPICIENCES 614 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 DPRITTY MELLIAN HOUSE SUMMARY STATEMENT OF DEPICIENCES 614 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 PRITTY MELLIAN HOUSE SUMMARY STATEMENT OF DEPICIENCES 614 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 PRITTY MELLIAN HOUSE 10 PRITTY MELLIAN HOUSE 10 PROVIDERS PLAN OF CORRECTION CHICK 12115 PRITTY MELLIAN HOUSE 10 PROVIDERS PLAN OF CORRECTION CHICK 12115 PRITTY MELLIAN HOUSE 10 PROVIDERS PLAN OF CORRECTION CHICK 12115 PRITTY STATE AND OF CORR | Division C | of Health Service Regu | lation | | | | |
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| been completed regarding the incident on | | | | | | | |
| 6/32/40: | | | rding the incident on | | | | |

Division of Health Service Regulation

-"They (staff working during the incident) should

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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | LTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED | |
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| ANDILAN | or connection | IDENTIFICATION NOMBER. | A. BUILDING: _ | | OOMI EETEB |
| | | | B. WING | | R-C |
| | | MHL049-123 | B. WING | | 06/28/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, STA | TE, ZIP CODE | |
| HELMS H | OUSE | | BYTERIAN ROA | | |
| | | MOORESV | /ILLE, NC 2811 | 5 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE |
| V 366 | Continued From page | e 43 | V 366 | | |
| | have but I'll have to c | heck " | | | |
| | nave but in have to c | neck. | | | |
| | revealed: | ent Report Form had been | | | |
| | | at the Incident Report Form | | | |
| | nad been completed | today (6/26/19). | | | |
| | | ssed referenced into 10A ope (V293) for a Type B and thin 45 days. | | | |
| V 536 | 27E .0107 Client Righ Int. | nts - Training on Alt to Rest. | V 536 | | |
| | to restrictive intervent (b) Prior to providing disabilities, staff inclu employees, students demonstrate compete completing training in other strategies for cr which the likelihood or injury to a person veright property damage is personal to the provider agencies based on state competed and demonstrated (d) The training shall include measurable testing (veright) | plement policies and size the use of alternatives tions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and reating an environment in if imminent danger of abuse with disabilities or others or revented. Is shall establish training etencies, monitor for internal constrate they acted on data | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 44 of 54

| DIVISION | n Health Service Regu | ialion | 1 | | | |
|---------------|---|--|------------------|--|-------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLI | ETED |
| | | | | _ | | |
| | | | B. WING | | R- | |
| | | MHL049-123 | D. WIING | | 06/2 | 8/2019 |
| NAME OF PR | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| | - | | BYTERIAN ROA | | | |
| HELMS HO | DUSE | | /ILLE, NC 281 | | | |
| | | MOURES | VILLE, NC 201 | 15 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | | COMPLETE DATE |
| IAG | | | IAG | DEFICIENCY) | | |
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| V 536 | Continued From page | e 44 | V 536 | | | |
| | | and a substitute that | | | | |
| | | e passing or failing the | | | | |
| | course. | | | | | |
| | | training must be completed | | | | |
| | • | der periodically (minimum | | | | |
| | annually). | | | | | |
| | (f) Content of the trai | | | | | |
| | provider wishes to em | nploy must be approved by | | | | |
| | the Division of MH/DD/SAS pursuant to | | | | | |
| | Paragraph (g) of this | Rule. | | | | |
| | (g) Staff shall demonstrate competence in the | | | | | |
| | following core areas: | | | | | |
| | • | and understanding of the | | | | |
| | people being served; | _ | | | | |
| | | and interpreting human | | | | |
| | behavior; | and interpreting namen | | | | |
| | • | the effect of internal and | | | | |
| | ` ' | | | | | |
| | | t may affect people with | | | | |
| | disabilities; | 1 9 8 | | | | |
| | | or building positive | | | | |
| | relationships with per- | | | | | |
| | ` ' | cultural, environmental and | | | | |
| | - | that may affect people with | | | | |
| | disabilities; | | | | | |
| | | the importance of and | | | | |
| | assisting in the perso | n's involvement in making | | | | |
| | decisions about their | | | | | |
| | (7) skills in asse | essing individual risk for | | | | |
| | escalating behavior; | | | | | |
| | | tion strategies for defusing | | | | |
| | | tentially dangerous behavior; | | | | |
| | and | | | | | |
| | (9) positive beh | navioral supports (providing | | | | |
| | • | n disabilities to choose | | | | |
| | activities which direct | | | | | |
| | behaviors which are u | | | | | |
| | (h) Service providers | | | | | |
| | | al and refresher training for | | | | |
| | | ai and refresher trailling to | | | | |
| | at least three years. | tion shall include: | | | | |
| | III IIOCIIMentai | non shall inclina' | 1 | 1 | | |

Division of Health Service Regulation

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| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 536 (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or | | MENT OF DEFICIENCIES AN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | CONSTRUCTION | (X3) DATE S | |
|--|-----------|--|---|-----------------|--|-------------|--------------------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 611 PRESBYTERIAN ROAD MOORESVILLE, NC 28115 (C4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 45 (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competence-by-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or | | | | A. BUILDING: _ | | | |
| HELMS HOUSE SUMMARY STATEMENT OF DEFICIENCIES (ACA) TO DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 45 (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or | | | MHL049-123 | B. WING | | 1 | |
| CALL DEPRETIX DEPRETIX CALL DEPRETIX DEP | NAME OF P | OF PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 45 (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competence-besides on testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or | | 0.1101105 | 611 PRESE | YTERIAN RO | AD | | |
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| (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or | PREFIX | IX (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF | BE | (X5) COMPLETE DATE |
| outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or | V 536 | Continued From page | e 45 | V 536 | | | |
| failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program | | (A) who particip outcomes (pass/fail); (B) when and with the provision review/request this did (i) Instructor Qualific Requirements: (1) Trainers ship scoring 100% on the aimed at preventing, need for restrictive in (2) Trainers ship scoring a passing instructor training processing instructor training processing and passing instructor training competency-based, in objectives, measurable methods failing the course. (4) The contenservice provider plans approved by the Divisto Subparagraph (i) (5) Acceptable shall include but are shall include but | where they attended; and name; nof MH/DD/SAS may ocumentation at any time. ations and Training all demonstrate competence testing in a training program reducing and eliminating the terventions. all demonstrate competence grade on testing in an orgam. It is shall be include measurable learning ole testing (written and by it ior) on those objectives and is to determine passing or the office of the instructor training the is to employ shall be sion of MH/DD/SAS pursuant of this Rule. Instructor training programs and limited to presentation of: ing the adult learner; or teaching content of the or evaluating trainee the or evaluating trainee orgam aimed at preventing, ting the need for restrictive one time, with positive | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 46 of 54

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE S COMPLI | |
|--------------------------|--|---|---------------------|---|-----------------------|--------------------------|
| | | | B WING | | R- | |
| | | MHL049-123 | B. WING | | 06/2 | 8/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | DRESS, CITY, STA | | | |
| HELMS H | OUSE | | BYTERIAN ROA | | | |
| | OLUMBA DV OT | | /ILLE, NC 2811 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| V 536 | Continued From page | e 46 | V 536 | | | |
| | aimed at preventing, need for restrictive intannually. (8) Trainers shainstructor training at let (j) Service providers documentation of inititraining for at least the (1) Docume (A) who particip outcomes (pass/fail); (B) when and who particip outcomes (pass/fail); (B) when and who particip outcomes (pass/fail); (C) instructor's (2) The Division request and review the (k) Qualifications of (1) Coaches sharequirements as a train (2) Coaches sharequirements as a train (3) Coaches sharequirements as a train (4) Coaches sharequirements as a train (5) Coaches sharequirements as a train (1) Documentation share for trainers. | reducing and eliminating the terventions at least once all complete a refresher east every two years. shall maintain al and refresher instructor ree years. entation shall include: ated in the training and the where attended; and name. In of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation iner. In all teach at least three times eing coached. Hall demonstrate eletion of coaching or loction. In all be the same preparation as evidenced by: ews and interview, the | | | | |
| | | ive interventions on initial audited staff (staff #1 and : | | | | |

Division of Health Service Regulation

Review on 6/27/19 of staff #1's personnel record

STATE FORM 6899 COUV11 If continuation sheet 47 of 54

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|---|-------------------------------|--------------------------|
| | | | A. BUILDING: _ | | R-0 | _ |
| | | MHL049-123 | B. WING | | 1 | 8/2019 |
| NAME OF PR | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, STA | TE, ZIP CODE | | |
| HELMS HO | DUSE | | BYTERIAN ROA | | | |
| | | MOORESV | /ILLE, NC 2811 | 5 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| V 536 | Continued From page | e 47 | V 536 | | | |
| | revealed: -A hire date of 4/24/19 -No documentation the restrictive intervention. Review on 6/27/19 of revealed: -A hire date of 5/8/19 -No documentation the restrictive intervention. Interviews on 6/28/19 revealed: | 9; at training on alternatives to as had been completed. staff #4's personnel record at training on alternatives to as had been completed. with staff #1 and #4 eted training on alternatives | | | | |
| | -During a staff meetin | g on 6/27/19, the Qualified nformed them that she | | | | |
| | revealed: -He was sure that bot alternatives to restrict -The Owner of the fact training and had the control of the surface of | cility had completed the certificates; to get in touch with the | | | | |
| | | ssed referenced into 10 A ope (V293) for a Type B and hin 45 days. | | | | |
| V 537 | 27E .0108 Client Right ITO | nts - Training in Sec Rest & | V 537 | | | |
| | ISOLATION TIME-OU | CAL RESTRAINT AND | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 48 of 54

PRINTED: 07/12/2019 FORM APPROVED

Division of Health Service Regulation

| DIVISION | n nealth Service Regu | ialion | | | | _ |
|---|---|--|------------------|--|------------|----------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | | |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: | | COMPLETED | | |
| | | B. WING | | R-C | | |
| MIII 040 400 | | | | | | |
| | | MHL049-123 | B: ******* | | 06/28/2019 | \dashv |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| 611 PRESBYTERIAN ROAD | | | | | | |
| HELMS H | DUSE | | VILLE, NC 281 | | | |
| | | | 1122, 110 201 | | | \dashv |
| (X4) ID | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | (- / | |
| PREFIX TAG | , | LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPR | | |
| 1710 | | , | 17.0 | DEFICIENCY) | | |
| | | | | | | ┪ |
| V 537 | Continued From page | e 48 | V 537 | | | |
| | time-out may be emp | loyed only by staff who have | | | | |
| | been trained and hav | | | | | |
| | | oper use of and alternatives | | | | |
| | | Facilities shall ensure that | | | | |
| | • | ploy and terminate these | | | | |
| | | ned and have demonstrated | | | | |
| | competence at least a | | | | | |
| | • | direct care to people with | | | | |
| | | | | | | |
| | | atment/habilitation plan | | | | |
| | includes restrictive interventions, staff including | | | | | |
| | service providers, em | | | | | |
| | volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out | | | | | |
| | | | | | | |
| | | se interventions until the | | | | |
| | training is completed | and competence is | | | | |
| | demonstrated. | | | | | |
| | | r taking this training is | | | | |
| | | etence by completion of | | | | |
| | | , reducing and eliminating | | | | |
| | the need for restrictive | | | | | |
| | (d) The training shall | be competency-based, | | | | |
| | include measurable le | earning objectives, | | | | |
| | measurable testing (v | vritten and by observation of | | | | |
| | behavior) on those objectives and measurable | | | | | |
| | methods to determine | e passing or failing the | | | | |
| | course. | | | | | |
| | (e) Formal refresher | training must be completed | | | | |
| | | der periodically (minimum | | | | |
| | annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | Paragraph (g) of this | | | | | |
| | | ng programs shall include, | | | | |
| | but are not limited to, | · · · | | | | |
| | | formation on alternatives to | | | | |
| | the use of restrictive i | | | | | |
| | | | | | | |
| | | on when to intervene nent danger to self and | | | | |
| | (unucistanung millin | ieni uanger io sen and | 1 | | | - 1 |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 49 of 54

| DIVISION | n nealth Service Regu | iation | | | | | | |
|---|---|-------------------------------|------------------|--|-------|--|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | | | | |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: | | COMPLETED | | | | |
| | | | | R-C | | | | |
| MIII 040 400 | | B. WING | | | | | | |
| MHL049-123 | | 2: :::::0 | | 06/28/2019 | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | | | |
| | 611 PRESBYTERIAN ROAD | | | | | | | |
| HELMS H | HELMS HOUSE MOORESVILLE, NC 28115 | | | | | | | |
| | | | VILLE, NO 201 | | | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | (- / | | | |
| TAG | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPR | | | | |
| | | | | DEFICIENCY) | | | | |
| | | | | | | | | |
| V 537 | Continued From page | e 49 | V 537 | | | | | |
| | others); | | | | | | | |
| | , . | n safety and respect for the | | | | | | |
| | | Ill persons involved (using | | | | | | |
| | | rictive interventions and | | | | | | |
| | incremental steps in a | | | | | | | |
| | • | • | | | | | | |
| | (4) strategies for of restrictive intervent | or the safe implementation | | | | | | |
| | | - | | | | | | |
| | (5) the use of e | emergency safety | | | | | | |
| | | | | | | | | |
| | | itoring of the physical and | | | | | | |
| | psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | importance and purpo | | | | | | | |
| | ` ' | tion methods/procedures. | | | | | | |
| | (h) Service providers | | | | | | | |
| | | al and refresher training for | | | | | | |
| | at least three years. | | | | | | | |
| | · / | tion shall include: | | | | | | |
| | , , | ated in the training and the | | | | | | |
| | outcomes (pass/fail); | | | | | | | |
| | (B) when and where they attended; and | | | | | | | |
| | (C) instructor's | | | | | | | |
| | (2) The Division | n of MH/DD/SAS may | | | | | | |
| | review/request this do | ocumentation at any time. | | | | | | |
| | (i) Instructor Qualification and Training Requirements: | | | | | | | |
| | | | | | | | | |
| | (1) Trainers sha | all demonstrate competence | | | | | | |
| | by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | (2) Trainers sha | all demonstrate competence | | | | | | |
| | | esting in a training program | | | | | | |
| | | eclusion, physical restraint | | | | | | |
| | and isolation time-out | | | | | | | |
| | | all demonstrate competence | | | | | | |
| by scoring a passing grade on testing in an | | | | | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 50 of 54

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|----------------------------|---|-------------------------------|--|
| 7.1.2 / 2.1.7 5. 55.1.1.25 1.51. | | .52 | A. BUILDING: _ | | | |
| MHL049-123 | | B. WING | | R-C 06/28/2019 | | |
| | | | | TE 710 0005 | 1 00/20/2010 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | DRESS, CITY, STA | | | |
| HELMS H | OUSE | | BYTERIAN RO | | | |
| | | MOORES | VILLE, NC 281 | 15 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE | |
| V 537 | Continued From page | e 50 | V 537 | | | |
| | instructor training pro | gram. | | | | |
| | (4) The training | | | | | |
| | | nclude measurable learning | | | | |
| | | le testing (written and by | | | | |
| | observation of behavi | ior) on those objectives and | | | | |
| | measurable methods | to determine passing or | | | | |
| | failing the course. | | | | | |
| | • • | t of the instructor training the | | | | |
| | service provider plans | | | | | |
| | • • | sion of MH/DD/SAS pursuant | | | | |
| | to Subparagraph (j)(6) Acceptable | instructor training programs | | | | |
| | | be limited to, presentation | | | | |
| | of: | be inflited to, presentation | | | | |
| | (A) understanding the adult learner; | | | | | |
| | | r teaching content of the | | | | |
| | course; | 3 | | | | |
| | (C) evaluation | of trainee performance; and | | | | |
| | (D) documentat | ion procedures. | | | | |
| | ` ' | all be retrained at least | | | | |
| | | strate competence in the use | | | | |
| | of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. | | | | | |
| | | | | | | |
| | (8) Trainers shall be currently trained in CPR. | | | | | |
| | | all have coached experience | | | | |
| | in teaching the use of restrictive interventions at | | | | | |
| | least two times with a positive review by the | | | | | |
| | coach. | • | | | | |
| | (10) Trainers shall teach a program on the | | | | | |
| | use of restrictive interventions at least once annually. | | | | | |
| | | | | | | |
| | | all complete a refresher | | | | |
| | instructor training at l | | | | | |
| | (k) Service providers | | | | | |
| | | al and refresher instructor | | | | |
| | training for at least th | - | | | | |
| | (1) Documenta | tion shall include: | 1 | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 51 of 54

| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|----------------------------|---|-------------------------------|--------------------------|
| | | A. BUILDING: _ | | | | |
| | | MHL049-123 | B. WING | | R- 06/2 | .C 28/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HELMS H | OUSE | 611 PRESE | SYTERIAN ROA | AD | | |
| HELINIS H | 003E | MOORESV | ILLE, NC 2811 | 15 | | _ |
| (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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| V 537 | Continued From page | e 51 | V 537 | | | |
| | (A) who particip outcome (pass/fail); (B) when and v (C) instructor's (2) The Division review/request this do (I) Qualifications of C (1) Coaches sh requirements as a tra (2) Coaches sh times, the course whi | where they attended; and name. In of MH/DD/SAS may ocumentation at any time. Coaches: Inall meet all preparation liner. Inall teach at least three lich is being coached. Inall demonstrate oletion of coaching or liction. Ishall be the same | | | | |
| | facility failed to ensur seclusion, physical re affecting 2 of 5 audite The findings are: Review on 6/27/19 of revealed: -A hire date of 4/24/1 -No documentation th physical restraint and completed. Review on 6/27/19 of revealed: -A hire date of 5/8/19 | ews and interview, the e staff were trained in estraint and isolation time-out ed staff (staff #1 and #4). f staff #1's personnel record 9; nat training on seclusion, l isolation time-out had been f staff #4's personnel record ; | | | | |
| -No documentation that training on seclusion, physical restraint and isolation time-out had been completed. | | | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 52 of 54

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---|---|-------------------------------|--------------------------|
| | | | 7.11.20.123.110. | | R-C | |
| | | MHL049-123 | B. WING | | 06/28/2 | 2019 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| HELMS H | DUSE | | SYTERIAN ROA | | | |
| | | | ILLE, NC 2811 | | | |
| (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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE (| (X5) COMPLETE DATE |
| V 537 | Continued From page | e 52 | V 537 | | | |
| | Interviews on 6/28/19 with staff #1 and #4 revealed: -They had not completed training on seclusion, physical restraint and isolation time-out; -During a staff meeting on 6/27/19, the Qualified Professional #2 had informed them that she would be scheduling the training soon. Interview on 6/28/19 with the Operations Manager revealed: -He was sure that both staff had been trained on seclusion, physical restraint and isolation time-out; -The Owner of the facility had completed the training and had the certificates; -He had been unable to get in touch with the Owner in order to obtain the certificates. This deficiency is crossed referenced into 10 A NCAC 27G .0201 Scope (V293) for a Type B and must be corrected within 45 days. | | | | | |
| V 744 27G .0304(b) Safety | | V 744 | | | | |
| | 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. | | | | | |
| This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure the facility was equipped in a manner that ensured the physical safety of clients, staff and visitors. The findings are: | | | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 53 of 54

| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | |
|------------------------|--|--|-----------------|--|------------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED | |
| | | | | | R-C | |
| | | MHL049-123 | B. WING | | 06/28/2019 | |
| NAME OF PF | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | - | |
| | | 611 PRESE | SYTERIAN ROA | AD | | |
| HELMS HO | DUSE | MOORESV | ILLE, NC 281 | 15 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | N (X5) | |
| PREFIX TAG | | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE | |
| V 744 | Continued From page | e 53 | V 744 | | | |
| | revealed: -A fire extinguisher statched kitchen; -A hanging tag from a attached to the fire exThe hanging tag reve was last serviced in F Interview on 6/27/19 of fire protection equipment hanging tag revealed representative from serviced the fire extinual basis. Interview on 6/28/19 of the revealed he was awas should have been insured to service the fire extinual basis. | ealed the fire extinguisher february 2018. with an individual with the ment company listed on the company had last guisher in February 2018; would have been due for 019 as fire extinguishers and serviced on an with the Operations Manager re that the fire extinguisher pected in February but had scheduling it. | | | | |

Division of Health Service Regulation

STATE FORM 6899 COUV11 If continuation sheet 54 of 54