STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL049-123	A. BUILDING: _____ B. WING _____	R-C 06/28/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 6/28/19. The complaint was substantiated (intake #NC00152026). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000	DHSR - Mental Health AUG 19 2019 Lic. & Cert. Section	
V 107	27G .0202 (A-E) Personnel Requirements 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 applicants for employment disclose any criminal	V 107		

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Plan of Correction June 2019 Helms House

Rule and the Violation

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 applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employee indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.

RDC Violation: A-E

This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a complete personnel file was maintained for 4 of 5 audited staff (staff #1, #2, #3, and #4). The findings are: Review on 6/27/19 of staff #1's personnel record revealed: -A hire date of 4/24/19; -No job description or documentation that indicated the staff met the minimum level of education was available. Review on 6/27/19 of staff #2's personnel record revealed: -A hire date of 4/25/19; -No job description or documentation that indicated the staff met the minimum level of education was available. Review on 6/27/19 of staff #3's personnel record revealed: -A hire date of 4/16/19; -No documentation that indicated the staff met the minimum level of 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.

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Solution: In accordance to 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS Rockwell Development Center will ensure that staff meet the minimum level of education by providing documentation to support their level of education completion. Employee files will be complete with job descriptions and education verifications.

This deficiency has been corrected by hiring of an HR person. Rockwell Development Center was functioning without this essential position. This position maintains employee files and the onboarding process for hiring. Further instances of this issue will be avoided by use of spreadsheets and checklist that ensure all necessary files are obtained and added to personnel records. The HR person shall monitor these corrections monthly or as new personnel are hired.

RDC Violation: F-I

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.
Review on 6/27/19 of staff #2's personnel record revealed: -A hire date of 4/25/19; -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. Review on 6/27/19 of staff #3's personnel record revealed: -A hire date of 4/16/19; 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. Review on 6/27/19 of staff #4's personnel record revealed: A hire date of 5/8/19; -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. Review on 6/27/19 of staff #5's personnel record revealed: -A hire date of 5/1/19; -No documentation the staff had completed training in basic first aid. Review on 6/27/19 of the staff schedule for June 2019 revealed there were 6 shifts in which there were no staff available that had been trained in first aid.

Solution: In accordance to 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS Rockwell Development Center will ensure that new hires are completing the minimum employee training including first aid and training on how to meet the needs of the mh/dd/sa population.

This deficiency has been corrected by hiring of an HR person. This position maintains employee files and the onboarding process for hiring. Further instances of this issue will be avoided by use of spreadsheets and checklist that ensure all necessary files are obtained and added to personnel records. The HR person shall monitor these corrections monthly or as new personnel are hired. This position additionally ensures that all initial trainings are completed and signed off on before new hires work their first shift in the home.

10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter

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referred to as the "plan," strategies to address the client's presenting problem shall be documented. (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.

RDC Violation:
This Rule is not met as evidenced by: V 112 Based on interviews and record reviews, the facility failed to develop and implement goals to reflect the needs of the clients affecting 1 of 4 clients (client #1). The findings are: Review on 6/27/19 of client #1's record revealed: -An age of 12 years old; -An admission date of 3/8/19; -Diagnoses included Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, multiple personalities and a history of sexual and physical abuse; -A Comprehensive Clinical Assessment dated 9/5/18 revealed the client had a history of urinating on her clothing and in her room; -A Comprehensive Clinical Assessment Addendum dated 1/10/19 revealed:-"[Client #1] will lapse into different personalities; one is a teenage boy, who [client #1] will lapse into frequently over the past couple of months;" -"[Client #1] will have an entire day where she is in this personality, and only wants to be addressed by [the boy's name];" -"One is a baby; it is reported that it does not last as long as the teenage boy personality;" -A Treatment Plan dated 2/27/19 that included the goals of: -"[Client #1] will learn personal boundaries and acceptable behaviors to decrease instances of inappropriate sexual or sexualized behaviors to zero;" -"[Client #1] will improve her communication skills and be able to discuss feelings towards transition from psychiatric residential treatment facility into level 3 group home and learn to verbalize her needs and desires in an appropriate manner in 3 of 5 situations;" -"Client will gain skills necessary to cope with traumatic event as evidenced by ability to function in daily life without persistent worries, flashbacks and avoidance of event for 5 out of 7 days a week for 3 consecutive months;" -No goals related to the client urinating on her clothing and in her room or her multiple personalities. Review on 6/28/19 of an Incident Report Form revealed: -Date/Time of Incident: 6/23/19 at 3:00am; -"In the middle of the night client (#1) got bored, left her room and took the keys for the house and let herself in the office and med (medication) closet and got the scissors;" -"Client (#1) then cut her hair and dress like a boy;" -"Client (#1) then hide the keys and went to bed."

Solution: In accordance to 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN Rockwell Development Center will ensure that plans specific to client's needs are developed and implemented within 30 days of admission for clients expected to stay longer than 30 days.

This deficiency has been corrected by the development and implementation of the client history and treatment plan form. This form is completed during the admission process and updated weekly during treatment team involving house managers and also updated during CFT's involving the consumer and their legal guardian. These forms will be reviewed at the CFT and will support the QP with updating the Person Centered plan. The QP will monitor these updates weekly at treatment team and ensure that they are updated monthly and integrated into the PCP.

10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is not required, a nurse or other designated person may assist a physician or other health

care practitioner with dispensing so long as the final label, container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone for take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10A NCAC 26E .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. (e) Medication Storage: (1) All medication shall be stored: (A) in a

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securely locked cabinet in a clean, well-lighted, ventilated room between 59º and 86º F.; (B) in a refrigerator, if required, between 36º and 46º F. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act and shall be in compliance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. (g) Medication education: (1) Each client started or maintained on a medication by an area program physician shall receive either oral or written education regarding the prescribed medication by the physician or their designee. In instances where the ability of the client to understand the education is questionable, a responsible person shall be provided either oral or written instructions on behalf of the client. (2) The medication education provided shall be sufficient to enable the client or other responsible person to make an informed consent, to safely administer the medication and to encourage compliance with the prescribed regimen. (3) The area program physician or designee shall document in the client record that education for the prescribed psychotropic medication was offered and either provided or declined. If provided, it shall be documented in what manner it was provided (either orally or written or both) and to whom (client or responsible person). (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted.

This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure 1 of 5 audited staff (#3) received medication training prior to administering medications affecting 4 of 4 clients (clients #1, #2, #3, and #4). The findings are: Review on 6/27/19 of staff #3's personnel record revealed: -A hire date of 4/16/19; -No documentation that medication training had been completed was available. Review on 6/27/19 of clients #2 and #3's MARs for the month of June revealed staff #3 had indicated that she administered medications to the clients.

Solution: In accordance to 10A NCAC 27G .0209 MEDICATION REQUIREMENTS Rockwell Development Center will ensure only staff who have received medication training will administer medications. Rockwell will additionally ensure that records verifying the completion of medication training will be in the personnel record.

This deficiency has been corrected by the hiring of an HR person who ensure that all trainings are up to date and documented in the personnel record. This person also schedules trainings for new hires and collects proof of completion. The HR person will ensure that these trainings are scheduled for individuals who are new hires or have expiring training certifications. This will be monitored monthly.

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§ 131E-256. Health Care Personnel Registry.

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility.

d1. Diversion of drugs belonging to a patient or client of the health care facility.

e. Fraud against a health care facility.

e1. Fraud against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(a1) The Department shall include in the registry a brief statement of any individual disputing the finding entered against the individual in the health care personnel registry pursuant to subdivision (1) of subsection (a) of this section.

(b) For the purpose of this section, the following are considered to be "health care facilities":

(1) Adult Care Homes as defined in G.S. 131D-2.1.

(2) Hospitals as defined in G.S. 131E-76.

(3) Home Care Agencies as defined in G.S. 131E-136.

(4) Nursing Pools as defined by G.S. 131E-154.2.

(5) Hospices as defined by G.S. 131E-201.

(6) Nursing Facilities as defined by G.S. 131E-255.

(7) State-Operated Facilities as defined in G.S. 122C-3(14)f.

(8) Residential Facilities as defined in G.S. 122C-3(14)e.

(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.

(10) Licensable Facilities as defined in G.S. 122C-3(14)b.

(11) Multiunit Assisted Housing with Services as defined in G.S. 131D-2.1.

(12) Community-Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C of the General Statutes.

(13) Agencies providing in-home aide services funded through the Home and Community Care Block Grant Program in accordance with G.S. 143B-181.1(a)11.

(c) For the purpose of this section, the term "health care personnel" means any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided.

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer at a health care facility or potential employer at a health care facility of any person listed on the Health Care Personnel Registry information concerning the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

(g1) Health care facilities defined in subsection (b) of this section are permitted to provide confidential or other identifying information to the Health Care Personnel Registry, including social security numbers, taxpayer identification numbers, parent's legal surname prior to marriage, and dates of birth, for verifying the identity of accused health care personnel. Confidential or other identifying information received by the Health Care Personnel Registry is not a public record under Chapter 132 of the General Statutes.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

(i) In the case of a finding of neglect under subdivision (1) of subsection (a) of this section, the Department shall establish a procedure to permit health care personnel to petition the Department to have his or her name removed from the registry upon a determination that:

(1) The employment and personal history of the health care personnel does not reflect a pattern of abusive behavior or neglect;

(1a) The health care personnel's name was added to the registry for a single finding of neglect;

(2) The neglect involved in the original finding was a singular occurrence; and

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(3) The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry under subdivision (1) of subsection (a) of this section.

(i1) Health care personnel who wish to contest a decision by the Department to deny a removal of a single finding of neglect from the Health Care Personnel Registry under subdivision (1a) of subsection (i) of this section are entitled to an administrative hearing under Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's denial of a removal of a finding of neglect.

(j) Removal of a finding of neglect from the registry under this section may occur only once with respect to any person. (1995 (Reg. Sess., 1996), c. 713, s. 3(b); 1998-212, s. 12.16E; 1999-159, s. 1; 2000-55, s. 1; 2004-203, ss. 52(a), (b), (c); 2007-544, s. 2; 2009-316, ss. 1(a), (b), 2; 2009-462, s. 4(m).

This Rule is not met as evidenced by: V 131 Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to hire for 4 of 5 audited staff (staff #1, #2, #3, and #4). The findings are: Review on 6/27/19 of staff #1's personnel record revealed: -A hire date of 4/24/19; -The HCPR was accessed on 6/27/19. Review on 6/27/19 of staff #2's personnel record revealed: -A hire date of 4/25/19; -The HCPR was accessed on 5/17/19. Review on 6/27/19 of staff #3's personnel record revealed: -A hire date of 4/16/19; -The HCPR was accessed on 5/17/19. Review on 6/27/19 of staff #4's personnel record revealed: -A hire date of 5/8/19;-The HCPR was accessed on 5/17/19.

Solution: In accordance to § 131E-256 Health Care Personnel Registry Rockwell Development Center will ensure all staff have no substantiated findings of abuse or neglect listed on the North Carolina Health Care personnel Registry prior to offer of employment.
This deficiency has been corrected by the hiring of an HR person who ensures that the HCPR is accessed for new hires and shall note each incident of access in the appropriate business files. The HR person will be responsible for monitoring these updates upon hire.

§ 122C-80. Criminal history record check required for certain applicants for employment.

(a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter.

(b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Public Safety under G.S. 143B-939 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section.

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Notwithstanding G.S. 143B-939, the Department of Public Safety shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Department of Public Safety data bank may conduct on behalf of a provider a State criminal history record check required by this 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 section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.

(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.

(2) The date of the crime.

(3) The age of the person at the time of the conviction.

(4) The circumstances surrounding the commission of the crime, if known.

(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.

(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.

(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

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(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:

(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.

(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.

(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7B, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots, Civil Disorders, and Emergencies; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 143B-939.

(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3; 2012-12, s. 2(tt); 2014-100, ss. 17.1(q), (ddd); 2015-181, s. 47.)

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This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a request for a criminal history record check was completed within five business days of a conditional offer of employment affecting 4 of 5 audited staff (staff #1, #2, #4, and #5). The facility also failed to ensure a request for a criminal history record check that included the applicant's fingerprints for applicant's that had been a resident of this State for less than five years, was completed within five business days of a conditional offer of employment affecting 1 of 5 audited staff (staff #3). The findings are: Review on 6/27/19 of staff #1's personnel record revealed:-A hire date of 4/24/19; -No documentation that a request for a criminal history record check was completed. Review on 6/27/19 of staff #2's personnel record revealed:-A hire date of 4/25/19; -A request for a criminal history record check was completed on 6/4/19. Review on 6/27/19 of staff #3's personnel record revealed: -A hire date of 4/16/19; The application indicated the staff had resided in another state between 3/2017 - 11/2018; No documentation that a request for a criminal history record check that included the staff's fingerprints was completed. Review on 6/27/19 of staff #4's personnel record revealed: -A hire date of 5/8/19; -No documentation that a request for a criminal history record check was completed. Review on 6/27/19 of staff #5's personnel record revealed: -A hire date of 5/1/19; -A request for a criminal history record check was completed on 6/4/19.

Solution: In accordance to § 122C-80. Criminal history record check required for certain applicants for employment Rockwell Development Center will ensure all staff have no substantiated findings of abuse or neglect listed on the North Carolina Health Care personnel Registry prior to offer of employment.
This deficiency has been corrected by the hiring of an HR person who ensures that the HCPR is accessed for new hires and shall note each incident of access in the appropriate business files. The HCPR will be accessed upon hire by the HR person.

SECTION .1700 - RESIDENTIAL TREATMENT STAFF SECURE FOR CHILDREN OR ADOLESCENTS 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.

This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide intensive, active therapeutic treatment and interventions inside the scope of residential services and failed to ensure continuous supervision affecting 4 of 4 clients (clients #1, #2, #3, and #4). The findings are: CROSS REFERENCE: 10A NCAC 27G .0202 Personnel Requirements (V107). Based on record reviews and interviews, the facility failed to ensure a complete personnel file was maintained for 4 of 5 audited staff (staff #1, #2, #3, and #4).

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CROSS REFERENCE: 10A NCAC 27G .0202 Personnel Requirements (V108). 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).
CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on interviews and record reviews, the facility failed to develop and implement goals to reflect the needs of the clients affecting 1 of 4 clients (client #1). CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V118). Based on record review and interviews the facility failed to ensure 1 of 5 audited staff (#3) received medication training prior to administering medications affecting 4 of 4 clients (clients #1, #2, #3, and #4).
CROSS REFERENCE: G.S. 131E-256 Health Care Personnel Registry (V131). Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to hire for 4 of 5 audited staff (staff #1, #2, #3, and #4).
CROSS REFERENCE: G.S. 122C-80 Criminal History Record Check Required for Certain Applicants for Employment (V133). Based on record reviews and interviews, the facility failed to ensure a request for a criminal history record check was completed within five business days of a conditional offer of employment affecting 4 of 5 audited staff (staff #1, #2, #4, and #5). The facility also failed to ensure a request for a criminal history record check that included the applicant's fingerprints for applicant's that had been a resident of this State for less than five years, was completed within five business days of a conditional offer of employment affecting 1 of 5 audited staff (staff #3).
CROSS REFERENCE: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296). Based on record reviews and interviews, the governing body failed to ensure at least two direct care staff members were present with every four children or adolescents affecting 3 of 4 surveyed clients (Clients #1, #2, and #3).
CROSS REFERENCE: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record review and interviews the facility failed to document their response to level 1 incidents.
CROSS REFERENCE: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536). Based on record reviews and interview, the facility failed to ensure staff were trained in alternatives to restrictive interventions on initial basis affecting 2 of 5 audited staff (staff #1 and #4).
CROSS REFERENCE: 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint and Isolation Time-Out (V537). Based on record reviews and interview, the facility failed to ensure staff were trained in seclusion, physical restraint and isolation time-out affecting 2 of 5 audited staff (staff #1 and #4).
CROSS REFERENCE: 10A NCAC 27G .0304 Facility Design and Equipment (V744). 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.

Solution: In accordance to SECTION .1700 - RESIDENTIAL TREATMENT STAFF SECURE FOR CHILDREN OR ADOLESCENTS 10A NCAC 27G .1701 SCOPE Rockwell Development Center will provide intensive, active therapeutic treatment and interventions inside the scope of residential services and will ensure continuous supervision.
This deficiency has been corrected by the hiring of an HR person who ensures that the HCPR is accessed for new hires and shall note each incident of access in the appropriate business files. The Licensed Professional and QP will ensure that treatment plans are updated and are operating within our scope weekly during treatment team.

10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake

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and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan.

This Rule is not met as evidenced by: Based on record reviews and interviews, the governing body failed to ensure at least two direct care staff members were present with every four children or adolescents affecting 3 of 4 clients (Clients #1, #2, and #3). The findings are: Review on 6/27/19 of client #1's record revealed: -An age of 12 years old; An admission date of 3/8/19; -Diagnoses included Post Traumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, a history of physical and sexual abuse, and multiple personalities; -A Comprehensive Clinical Assessment dated 9/5/18 included:-"[Client #1] is believed to have experienced physical and sexual abuse from her step-father as well as witnessing the abuse of other children in the home, and her mother was aware of the abuse;" -"She has difficulty respecting boundaries within a home setting, and will take things that do not belong to her;"-"...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. Review on 6/27/19 of client #3's record revealed: -An age of 13 years old; -An admission date of 6/18/19; -Diagnoses included DMDD and a history of sexual abuse; -A Comprehensive Clinical Summary dated 5/23/19 revealed..."mood symptoms began around the age of 10 and [client #3's] behaviors progressed to aggression at home and at school, AWOL (absent without official leave), poor academic performance, and meeting up with adult males to potentially have sex with them;" -A Treatment Plan dated 5/23/19 revealed no documentation that indicated based on the client's strengths and needs she was able to be transported by one staff.

Solution: In accordance to 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents.

This deficiency has been corrected by the hiring of an HR person who ensures that the schedule communicate the correct ratio of staff per client. The HR person has implemented a policy to ensure that staff are communicating with management if their support staff hasn't arrived on time; if an employee will be late for their shift requiring additional coverage; if staff has to be relieved of their duties while on shift. Management should be notified immediately and PRN staff will be contacted. These efforts will be monitored daily by the QP, HR person and Operations Manager.

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10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall 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; (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 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 (D) issue a final written report signed by the 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 LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.

This Rule is not met as evidenced by: Based on record review and interviews the facility failed to document their response to level 1 incidents. The findings are: Review on 6/28/19 of Incident Report Form: Level 1 revealed: -Type of Incident: Shaved Head; -Date/Time of Incident: 6/23/19/3:00am; -"In the middle of the night client (#1) got bored, left her room and took the keys for the house and let herself in the office and med closet and got the scissors;" -"Client (#1) then cut her hair and dress like a boy;" "Client (#1) then hide the keys and went to bed;" -QP notified date/time: Blank -Legally responsible person notified date/time: Blank -Name and Title of Staff Completing Form: Staff 7- "staff not present but notified;" -Name and title of person reviewing form: Blank; -Signature/Date of reviewer: Blank; -Comments: Blank.

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Solution: In accordance to 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS SCOPE Rockwell Development Center will implement written policies governing their response to level I, II or III incidents. Current policies are developed and implemented. Personnel are required to turn in incident reports in 24 hours to ensure that IRIS reports are filed within 72 hours.
This deficiency was personnel specific and this staff has been relieved of duties at Rockwell Development Center. The QP will continue to monitor incident reports daily. Rockwell Development Center will prevent lapse in incident reports being submitted by following up with staff within 24 hours of incident to ensure that their IR's are submitted.

10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) 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 failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ 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: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (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 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

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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 aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. **(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers.**

This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure staff were trained in alternatives to restrictive interventions on initial basis affecting 2 of 5 audited staff (staff #1 and #4). The findings are: Review on 6/27/19 of staff #1's personnel record -A hire date of 4/24/19; No documentation that training on alternatives to restrictive interventions had been completed. Review on 6/27/19 of staff #4's personnel record revealed: A hire date of 5/8/19; No documentation that training on alternatives to restrictive interventions had been completed.

Solution: In accordance to 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS Rockwell Development Center will ensure that our facility shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. The current practice is Mindset and is taught prior to working a shift in the facility.
This deficiency has been corrected by hiring of an HR person. This position maintains employee files and the onboarding process for hiring including Mindset training. The HR person will monitor for these training needs monthly or upon hire.

10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIMEOUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) 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 failing the course. (e) Formal refresher training must be completed by each service provider 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 Rule. (g) Acceptable training programs shall include, but are not

limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring 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 purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (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 Qualification 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 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) 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 failing the course. (5) 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 (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate 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. (9) Trainers shall 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. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (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. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.

This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure staff were trained in seclusion, physical restraint and isolation time-out affecting 2 of 5 audited staff (staff #1 and #4).
The findings are: Review on 6/27/19 of staff #1's personnel record revealed: -A hire date of 4/24/19; No documentation that training on seclusion, physical restraint and isolation time-out had been completed.
Review on 6/27/19 of staff #4's personnel record revealed:-A hire date of 5/8/19; No documentation that training on seclusion, physical restraint and isolation time-out had been completed.

Solution: In accordance to 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIMEOUT Rockwell Development Center will ensure that seclusion, physical restraint and

isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. The current practice is Prevention and Management of Aggressive Behavior (PMAB) and is taught prior to working a shift in the facility.
This deficiency has been corrected by hiring of an HR person. This position maintains employee files and the onboarding process for hiring including PMAB training. The HR person will monitor training needs upon hire and as certificates expire. This monitoring will occur monthly.

10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (a) Privacy: Facilities shall be designed and constructed in a manner that will provide clients privacy while bathing, dressing or using toilet facilities. (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (1) All hallways, doorways, entrances, ramps, steps and corridors shall be kept clear and unobstructed at all times. (2) All mattresses purchased for existing or new facilities shall be fire retardant. (3) Electrical, mechanical and water systems shall be maintained in operating condition. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. (5) All indoor areas to which clients have routine access shall be well-lighted. Lighting shall be adequate to permit occupants to comfortably engage in normal and appropriate daily activities such as reading, writing, working, sewing and grooming. (c) Comfort Zone: Each 24-hour facility shall provide heating and air-cooling equipment to maintain a comfort range between 68 and 80 degrees Fahrenheit. (1) This requirement shall not apply to therapeutic (habilitative) camps and other 24-hour facilities for six or fewer clients. (2) Facilities licensed prior to October 1, 1988 shall not be required to add or install cooling equipment if not already installed. (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (1) Client bedrooms shall have at least 100 square feet for single occupancy and 160 square feet when two clients occupy the bedroom. (2) Where bassinets and portable cribs for infants are used, a minimum of 40 square feet per bassinet or portable crib shall be provided. (3) No more than two clients may share an individual bedroom regardless of bedroom size. (4) In facilities with overnight accommodations for persons other than clients, such accommodations shall be separate from client bedrooms. (5) No client shall be permitted to sleep in an unfinished basement or in an attic. (6) In a residential facility licensed under residential building code standards and without elevators, bedrooms above or below the ground level shall be used only for individuals who are capable of moving up and down the steps independently. (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client. (8) Only clients of the same sex may share a bedroom except for children age six or below, and married couples. (9) Children and adolescents shall not share a bedroom with an adult. (10) At least one full bathroom for each five or fewer persons including staff of the facility and their family shall be included in each facility. (11) Each facility, except for a private home provider, shall have a reception area for clients and visitors and private space for interviews and conferences with clients. (12) The area in which therapeutic and habilitative activities are routinely conducted shall be separate from sleeping areas. (e) Where strict conformance with current requirements would be impractical, or because of extraordinary circumstances, new programs, or unusual conditions, DFS may approve alternate methods, procedures, design criteria and functional variations from the

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physical plant requirements when the facility can effectively demonstrate to DFS's satisfaction that the: (1) intent of the physical plant requirements are met; and (2) variation does not reduce the safety or operational effectiveness of the facility.

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: Observation on 6/27/19 at approximately 9:20am revealed: A fire extinguisher stored underneath the sink in the kitchen; -A hanging tag from a fire protection company attached to the fire extinguisher; The hanging tag revealed the fire extinguisher was last serviced in February 2018.

Solution: In accordance to 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT Rockwell Development Center will ensure that seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. The current practice is Prevention and Management of Aggressive Behavior (PMAB) and is taught prior to working a shift in the facility.
This deficiency has been corrected and fire extinguishers were filled on 7-10-2019. The maintenance staff will ensure monthly that all fire extinguishers are working and are not expired.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL049-123 (Y1)	A. Building B. Wing (Y2)	6/28/2019 (Y3)

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0109 Reg. # 27G .0203 LSC	Correction Completed 06/28/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Shari Spicer	7/16/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/15/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO