STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	07/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	E 039	This deficiency will be corrected by the following actions: A. Home Manager will provide training to all Direct Support Professionals on the Emergency Plan for the group home. This training will include either a full-scale exercise or a tabletop exercise designed to test the Direct Support Professionals' readiness to act in an emergency. B. Home Manager will document training of Direct Support Professionals on an in-service sheet and keep on file at the group home. C. Home Manager will monitor all drills, especially those relating to the Emergency Plan, on a weekly basis. Home Manager will sign these drills to indicate that they were reviewed. D. Home Manager and Clinical Supervisor will coordinate tabletop or full-scale exercises at least once per year. E. Program Manager will review documentation for these drills monthly. DHSR - Mental Health AUG 08 2019 Lic. & Cert. Section	9/20/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: BA/CP | TITLE: Program Manager | (X6) DATE: 8/6/19

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 039	Continued From page 1 *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is: The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise. Review on 7/22/19 of the facility's current EP plan (updated 4/15/19) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 7/23/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop	E 039	Please see Page 1.	

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E 039	Continued From page 2 exercise to test the effectiveness of their current emergency plan.	E 039	Please see Page 1.	
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain a comprehensive evaluation on the chart, for 1 of 3 audit clients (#4). The finding is: The physical therapy evaluation was not placed on the chart, for review, until 4 months after client #4's admission. Review on 7/22/19 of client #4's record revealed that an initial physical therapy (PT) evaluation was not on the chart. During an interview with the Qualified Intellectual Disabilities Professional (QIDP) on 7/23/19, he shared that he spoke to the physical therapist this morning about the PT evaluation and learned that she had visited the client after the admission, but had been busy and had not forwarded the evaluation before now. The QIDP stated that clients are assessed after admission, then again, every quarter. On 7/23/19 at 11:05 am, QIDP produced a copy of the physical therapy initial report, dated 3/26/19.	W 111	This deficiency will be corrected by the following actions: A. Clinical Supervisor will review all charts to ensure assessments from consultants are current. Clinical Supervisor will coordinate with consultants to ensure that any assessments that are out of date are updated within the stated time frame. B. Clinical Supervisor will revise any ISP's that need to be revised based on new/updated assessments from any of the consultants. C. Clinical Supervisor will train all Direct Support Professionals on new assessments/guidelines for the consumers in the home should they be put into place. D. Clinical Supervisor will document training of Direct Support Professionals on an in-service sheet and keep on file at the group home. E. Direct Support Professionals will document their training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. F. Clinical Supervisor will monitor assessments from consultants monthly to ensure that they are current.	9/20/2019
W 229	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(i)	W 229	Please see Page 4.	

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W 229	Continued From page 3 The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure objective statements for 1 of 3 audit clients (#1) were written in terms of a single behavioral outcome. The finding is: Client #1's objectives were not written with single outcomes. Review on 7/22/19 of client #1's Individual Program Plan (IPP) dated 3/26/19 revealed the objectives, "[Client #1] will complete the medication process and be aware of his medication with 100% independence for 6 consecutive months" and "Staff will prompt [Client #1] to begin the process of completing the laundry. [Client #1] will complete process of washing, drying and folding his clothes according to task analysis wit 100% independence for 6 months." During an interview on 7/23/19, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the objective statements were not written with single outcomes.	W 229	This deficiency will be corrected by the following actions: A. Clinical Supervisor will ensure all ISP's are current and that the accompanying goals are single-outcome based. If multiple areas need addressing, the Clinical Supervisor will ensure that each has a goal to address it separate from the other goals. B. Clinical Supervisor will train Direct Support Professionals on any ISP's that have had revisions to ensure they are trained on how to provide support to the consumer based on their goals/objectives. C. Direct Support Professionals will document their training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. D. Clinical Supervisor will maintain the ISP's for all consumers through monthly service notes and summaries. E. Program Manager will monitor these notes and summaries for completion and accuracy monthly.	9/20/2019
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active	W 249	Please see Page 5.	

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W 249	Continued From page 4 treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 3 audit clients (#1) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of medication administration. The finding is: Client #1's medication administration objective was not implemented as written. During observations of medication administration in the home on 7/23/19 at 6:35am, client #1 obtained his medication bin, retrieved his pill packs, punched his pills, scanned his pill cards, ingested his medications with water and threw away his trash. Interview on 7/23/19 with Staff D revealed all clients are encouraged to be as independent as possible during the medication pass. The staff did not identify any specific medication administration goals for client #1. Later interview with the staff confirmed client #1 has an objective for medication administration. Review on 7/22/19 of client #1's IPP dated 3/26/19 revealed an objective to complete the medication process and be aware of his medication with 100% independence. Additional	W 249	This deficiency will be corrected by the following actions: A. Clinical Supervisor and/or Home Manager will train Direct Support Professionals on the goals/objectives of all consumer ISP's to ensure those goals/objectives are being addressed as written. The training will also stress the importance of encouraging the consumers to be as independent as possible when working on their goals/objectives. B. Direct Support Professionals will document their training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. C. Clinical Supervisor will monitor Direct Support Professionals 2x/week. D. Home Manager will monitor Direct Support Professionals 3x/week. E. Program Manager will monitor this process 1x/month through review of observation forms completed by the Home Manager and/or Clinical Supervisor.	9/20/2019

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W 249	Continued From page 5 review of the objective included steps to: Retrieve his medication box, Wash his hands, Match pill pack to the MAR, State the side effects of medication, Take meds, Sign MAR in program book and Throw away trash. Interview on 7/23/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the medication administration objective should have been implemented during client #1's medication pass.	W 249	Please see Page 5.	
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Program Plan (IPP) was revised after client #1 had completed an objective. This affected 1 of 3 audit clients. The finding is: Client #1 continued training on an objective after its completion. Review on 7/22/19 of client #1's IPP dated 3/26/19 revealed an objective to complete the medication process and be aware of his medication with 100% independence for 6 consecutive months (implemented 9/1/17). Review of progress notes for the objective revealed the following:	W 255	This deficiency will be corrected by the following actions: A. Clinical Supervisor will train Direct Support Professionals on all ISP's with specific focus on addressing the needs of the consumers as stated in their goals as those goals are currently written. B. Direct Support Professionals will document their training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. C. Clinical Supervisor will monitor Direct Support Professionals 2x/week. D. Home Manager will monitor Direct Support Professionals 3x/week.	9/20/2019

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W 255	Continued From page 6 07/18 - 100% Independence 08/18 - 100% Independence 09/18 - 100% Independence 10/18 - 100% Independence 11/18 - 100% Independence 12/18 - 100% Independence During an interview on 7/23/19, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the objective had been completed.	W 255	Please see Page 6.	
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #1's Individual Program Plan (IPP) was reviewed and revised after the client failed to make progress on an objective. This affected 1 of 3 audit clients. The finding is: Client #1 failed to progress towards an identified objective. Review on 7/22/19 of client #1's IPP dated 3/26/19 revealed an objective to complete the process of washing, drying and folding his clothes according to task analysis with 100% independence for 6 months (implemented 9/1/17). Additional review of progress notes for the objective indicated the following:	W 257	This deficiency will be corrected by the following actions: A. Clinical Supervisor will ensure all ISP's are current and do not include goals to address stated objectives and which have already been completed as written. These plans will also be reviewed at a minimum of once per year. B. Clinical Supervisor will train Direct Support Professionals on all ISP's with specific focus on addressing the needs of the consumers as stated in their goals as those goals are currently written. C. Direct Support Professionals will document their training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. D. Clinical Supervisor will monitor Direct Support Professionals 2x/week. E. Home Manager will monitor Direct Support Professionals 3x/week.	9/20/2019

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W 257	Continued From page 7 07/18 - 82% 08/18 - 100% 09/18 - 100% 10/18 - 90% 11/18 - 46% 12/18 - 100% 01/19 - 99% 02/19 - 100% 03/19 - 93% 04/19 - 100% 05/19 - 85% Interview on 7/23/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objective needed to be revised.	W 257	Please see Page 7.	
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure written informed consent was obtained from both guardians for restrictive Behavior Support Plans (BSP). This affected 2 of 3 audit clients (#1, #5). The finding is: Written informed consent was not obtained from both parents for a restrictive BSP for two clients. a. Review on 7/22/19 of client #1's record revealed both of his parents are his legal guardians. Additional review of the client's BSP	W 263	This deficiency will be corrected by the following actions: A. Clinical Supervisor will review all documentation requiring parent/guardian signatures/consents to ensure that they are completed properly, especially those focused on restrictive interventions as stated in a formal BSP. B. Clinical Supervisor will get any documentation that needs to be signed, but is not, signed by the appropriate parent/guardian. If there is more than one legal guardian, the Clinical Supervisor will ensure that signatures from both guardians are obtained. C. Clinical Supervisor will monitor these documents and a minimum of 1x/year at each consumers ISP meeting but will update as needed should changes need to be made.	9/20/2019

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W 263	Continued From page 8 dated 3/26/19 revealed objectives to address inappropriate vocalizations and invasion of privacy. Review of the plan included restrictive medications used to address the client's inappropriate behaviors. Further review of a consent for the BSP indicated only one of two guardians had given their written informed consent for the plan on 4/14/19. b. Review on 7/22/19 of client #5's record revealed both of his parents are his legal guardians. Additional review of the client's BSP dated 3/26/19 revealed objectives to address non-compliance, inappropriate verbalization and elopements, requiring the use of door chimes for monitoring. Further review of a consent for the BSP indicated only one of two guardians had given their written informed consent for the plan on 3/26/19. Interview on 3/12/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed both parents for client #1 and client #5 are their legal guardians; however, only one of two guardians had signed the written informed consent forms.	W 263	Please see Page 8.	
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 5 clients observed receiving	W 369	Please see Page 10.	

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W 369	Continued From page 9 medications (#4). The finding is: Client #4's Flonase was not administered as ordered. During observations of medication administration in the home on 7/23/19 at 6:10am, Staff D administered Flonase 50mcg, 1 spray in each nostril to client #4. Interview on 7/23/19 with Staff D revealed client #4 routinely receives one spray of Flonase per nostril. Review on 7/23/19 of client #4's physician's orders dated 7/23/19 revealed an order for Flonase 50mcg, instill 2 sprays in each nostril once daily. Interview on 7/23/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4's Flonase order was current and should have been administered as ordered.	W 369	This deficiency will be corrected by the following actions: A. Home Manager and RN will ensure that any medication error is properly documented. B. RN will train all Direct Support Professionals in proper medication administration procedures, to include additional observations if deemed necessary. C. RN will ensure that Direct Support Professionals sign at minimum of an in-service sheet while conducting this training. D. Home Manager will monitor Direct Support Professionals completing medication administration to the consumers 2x/week. E. RN will monitor Direct Support Professionals completing medication administration to the consumers 2x/month.	9/20/2019

August 6, 2019

Wilma Worsley-Diggs, M.Ed., QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Plan of Correction for Recertification Survey
Helmsdale Group Home, 1317 Helmsdale Dr., Cary, NC 27513
Provider Number: 34G253
MHL Number: MHL-092-107

Dear Mrs. Worsley-Diggs,

Thank you for your time and the feedback given during the survey you completed on July 23, 2019. We appreciate your diligence in assisting us in providing the best care possible to the consumers we serve. We look forward to making the recommended changes that will improve the services we provide.

Enclosed you will the Plan of Correction. If you have any questions, please call me at (919) 387-1011 ext. 217. Again, thank you for your time and patience.

Sincerely,

Gary J. Ricci II, BA/QP
Program Manager, CANC

Enclosures