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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
W 000	INITIAL COMMENTS A complaint survey was completed on 2/25/2020. Deficiencies were cited as a result of the complaint survey for Intake #NC00160946. The complaint allegation was substantiated.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to implement written policies and procedures that prohibit neglect of clients (W149) and failed to ensure that direct care staff immediately reported all allegations of neglect to the administrator and other officials as required by policy (W153). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protection to its clients.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure it's policies and procedures were implemented to prevent neglect and ensure client safety and supervision	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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were followed for 3 of 3 audit clients (#1, #3, #4). The finding is:

Staff failed to ensure client #1 was adequately supervised to prevent him from biting and scratching clients #3 and #4.

During observations on 2/25/20 in the facility at 3:00 pm, client #1 arrived home from school and remained in the living room with two other clients. Client #1 was not kept within arm's reach of Staff A and Staff B for 22 minutes.

A record review on 2/25/20 of daily body audits in the last quarter of 2019 for client #3 revealed the following biting incidents initiated by client #1:

9/27/19 client #3 was bitten on right arm by client #1.
10/21/19 client #3 was bitten on right arm by client #1.
11/1/19 client #3 was bitten on right arm by client #1.
11/3/19 client #3 was bitten on right arm by client #1.
12/4/19 client #3 was bitten on arm by client #1.

A record review on 2/25/20 of daily body audits for January 2020 for client #4 revealed the following biting incidents initiated by client #1:

12/1/19 client #4 had bite mark on shoulder from client #1.
1/1/20 client #4 had bite marks on back from client #1.
1/4/20 client #4 had bite mark on chest from client #1.
1/5/20 client #4 had bite marks on right arm from client #1.

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1/9/20 client #4 had bite mark on back from client #1.
1/14/20 client #4 had bite mark on back, chest and arms from client #1.

A subsequent review of client #4's incident reports found:

On 12/1/19 at 4:30 pm, client #1 came into the bedroom of client #4 and bit him on the right arm. First aide given; no interventions recorded; 12/21/19 at 6:00 pm, client #4 was sitting in living room, watching the television, when client #1 became aggressive and bit client #4 on the right arm. Home Manager #1 (HM #1) was notified, no known actions taken; 1/4/20 at 12:30 pm, client #4 was walking to his room, when encountered client #1 who was having a behavior. Client #1 bit client #4 on the chest and right arm. HM #1 was notified; 1/8/20 at 6:30 pm, client #1 was having a behavior in the living room, when he grabbed his left arm and bit client #4. HM #1 was notified.

Interview on 2/25/20 with Staff A revealed that client #1's biting behavior was very random, however she has noticed that he will throw a ball toward other clients, so that he can get near them, to bite. When Staff A observed client #1 biting others, she would separate the clients or relocate client #1 to his bedroom, that has a door chime for monitoring his exits or in the office with her. Staff A mentioned that clients #3 and #4 bedrooms were on the same hall as client #1, which is on the other side of the house. Staff A stated that client #1 needed to be watched but not constant visual supervision.

Interview on 2/25/20 with Staff B revealed that client #1 had 4 incidents during this school year

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where he has bitten 2 students. Client #1 had also bitten his teacher on 2/7/2020. Client #1 was required to have 1:1 supervision at school but did not have 1:1 supervision at home.

Interview on 2/25/2020, by telephone with the former house manager 2 (HM #2), revealed that client #1 was the known aggressor in the group home. He would target new clients and any client who did not respond to his attacks. HM #2 knew of an incident that took place on a Friday, the third week in January. Client #1 had bitten client #4 on his arm and when the guardian of client #4 visited and saw the injury, client #4 was transported to the hospital. Staff working during the incident Staff A, Staff C and D and the former HM #1. Client #4 did not return to the home.

Additional interviews with HM #2 revealed that client #2 was supposed to be kept within arm's reach. Client #1 did not have incidents on third shift, since he slept through the night. HM #2 recalled that most of the biting incidents took place on weekends and 2nd shift. Last month, the staff received an in-service regarding supervising client #1 and staff were expected to be "more hands on." HM #2 was not aware if anymore incidents had taken place.

Review on 2/25/20 of client #1's individual program plan (IPP) dated 1/21/20 revealed an attached addendum, dated 6/1/18 that client #1 required 1 on 3 supervision at all times during awake hours. The IPP also noted that client #1 had several psychotropic medication changes throughout the year with an overall decrease in behaviors. However, it was revealed that client #1 still had concerns with aggressive behaviors when he experienced anxiety or became

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aggressive if he sees something that he wants and cannot have it.

Review on 2/25/20 of client #1's chart indicated that a document dated 1/21/20 for a bedroom door alarm. The purpose of the door alarm was to monitor client #1 who had a history of exiting his bedroom at night and entering the bedrooms of his housemates and sometimes becoming physical and attempting to bite his housemates. The alarm would provide a warning for support staff to alert them of any attempts to exit client #1's bedroom; as a necessity to ensure the rights of the individuals are upheld. The door alarms provide a warning to support staff to alert them of any attempts at exiting his bedroom without staff supervision.

The review on 2/25/20 of notes from an in-service 1/21/20 with staff, identified the need for monitoring all consumers in the home. It was noted that client #1 had been involved in several incidents where he had attacked his housemates leaving scratch and bite marks. Staff needs to follow protocol when reporting incidents to the nurse and the home manager. Staff were required to keep client #1 in eye sight at all times during awake hours and keep him in arms reach as much as possible.

During a phone interview on 2/25/20 with qualified intellectual disabilities professional (QIDP), he revealed that client #1 did not have 1:1 supervision but staff were supposed to keep up with him, especially if he was around others. QIDP indicated that last month, client #4's parent visited and saw the bite marks on the arm and became very upset. QIDP went to the home, to examine client #4's injuries, noted there was no

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broken skin. He in-serviced the staff on reporting and maintaining supervision. QIDP shared that staff had indicated to him, that they were on the other side of the house, when the incident took place. The HM #1 who was present the day of the last incident between clients #1 and #4 was no longer working in the home.

A review of the internal policy on Abuse, Neglect and Exploitation on 2/25/20 revealed neglect to be defined as a failure of an individual to provide the treatment, care, goods or services that are necessary to maintain the health or safety or a person we support.

After the staff inservice on 1/21/20, review of accident/incident reports, substantiated by interview with the QIDP, revealed client #1's biting behaviors have continued. Review of client #3's incident reports revealed: On 1/30/20, 2/3/20, 2/7/20 and 2/12/20, that he continued to be bitten by client #1.

In that the facility has not assured client #1 was adequately supervised as evidenced by continued biting of client #3 by client #1 and evidenced by staff not monitoring the client appropriately for 22 minutes during observations on 2/25/20, the facility has neglected to provide adequate supervision to protect the clients.

W 153 — W 153

STAFF TREATMENT OF CLIENTS
CFR(s): 483.420(d)(2)

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through

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W 153	Continued From page 6 established procedures. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure the administrator was notified immediately of incidents that may require investigation. This affected 3 of 3 clients (#1, #3 and #4). The finding is: Staff failed to notify the administrator of incidents of client #1 biting clients #3 and #4, so that the incidents could be thoroughly investigated. The review on 2/25/20 of notes from an in-service 1/21/20 with staff, identified the need for monitoring all consumers in the home. It was noted that client #1 had been involved in several incidents where he had attacked his housemates leaving scratch and bite marks. Staff needs to follow protocol when reporting incidents to the nurse and the home manager. Staff were required to keep client #1 in eye sight at all times during awake hours and keep him in arms reach as much as possible. During a phone interview on 2/25/20 with the qualified intellectual disabilities professional (QIDP), he revealed that staff were supposed to keep up with client #1 because he had a history of aggression that resulted in biting some of the clients. QIDP acknowledged that he was aware of some of the biting incidents, but the home manager #1 (HM #1) did not inform him of every incident. His expectation was that when an incident took place, staff should document on incident report and notify a HM. The HM would determine if the nurse needed to be contacted to treat an injury. Staff had been trained to keep him	W 153		

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W 153	Continued From page 7 informed of any incident. On 1/21/20, QIDP went to the home to in-service staff on reporting and maintaining supervision. QIDP shared that HM #1 was no longer working in the home.	W 153		
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The facility must ensure that specific active treatment services requirements are met. The facility failed to assure: Each client received a continuous active treatment program, which included aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that was directed towards the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible (196); that supervision was provided consistently as indicated in 3 of 3 audit clients' individual program plan (W249). Cross reference W 249.	W 195		
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for	W 196		

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W 196	Continued From page 8 the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on record reviews and staff interviews, the team failed to assure that a continuous active treatment program was implemented for 1 of 3 audit clients (#1) which provided consistent implementation of the individual program plan (IPP) and interventions in the facility, which promoted client function with as much independence as possible and prevented regression of acquired skills. The finding is: Staff failed to maintain visual supervision of client #1 during awake hours to prevent unwanted bite and scratch marks on other clients.	W 196		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, the team failed to implement sufficient interventions to support the achievement of client	W 249		

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#1's behavior support plan (BSP). This affected 1 of 3 clients (#1). The finding is:

Staff failed to maintain visual supervision of client #1 during waking hours to prevent unwanted bite and scratch marks on other clients.

During observations on 2/25/20 in the facility at 3:00 pm, client #1 arrived home from school and remained in the living room with two other clients. Client #1 was not kept within arm's reach of Staff A and Staff B for 22 minutes. In addition, on 2/25/20 a tour of the bedroom corridor, verified that client #1's room had a working door chime in place.

Review on 2/25/20 of client #1's individual program plan (IPP) dated 1/21/20 revealed an attached addendum, dated 6/1/18 that client #1 required 1 on 3 supervision at all times during awake hours. The IPP also noted that client #1 had several psychotropic medication changes throughout the year with an overall decrease in behaviors. However, it was revealed that client #1 still had concerns with aggressive behaviors when he experienced anxiety or became aggressive if he sees something that he wants and cannot have it.

The review on 2/25/20 of client #1's BSP 1/16/19 reflected that physical aggression was a targeted behaviors, but it did not specifically mentioned that he bit others.

A record review on 2/25/20 of daily body audits for client #3 revealed the following dates for incidents of client #1 inflicting bite marks: 9/27/19, 10/21/19, 11/1/19, 11/3/19, 12/4/19, 1/30/20, 2/3/20, 2/7/20 and 2/12/20.

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W 249	Continued From page 10 A record review on 2/25/20 of daily body audits in January 2020 for client #4 revealed the following dates for incidents of client #1 inflicting bite marks: 12/1/19, 1/1/20, 1/4/20, 1/5/20, 1/9/20 and 1/14/20. In addition, the review on 2/25/20 of clients #3 and #4 body audit logs documented that there were repeated incidents since December 2019 where they both were scratched and bitten by client #1. Staff would document if a referral to the nurse was made in order to garner first aide treatments. However, there was no language about corrective action plan for repeated incidents of lack of supervision by staff, that led to bite marks and scratches, inflicted by client #1. A subsequent review of client #4's incident reports found the following dates when client #1 was not properly supervised and bit client #4: 12/1/19 at 4:30 pm, 12/21/19 at 6:00 pm, 1/4/20 at 12:30 pm and 1/8/20 at 6:30 pm. HM #1 was notified of the incidents. Interview on 2/25/20 with Staff A revealed that she was aware that client #1 had a long history of biting other clients in the home. Staff A was not able to attest to client #1's current level of supervision. Instead Staff A stated that client #1 needed to be watched but not constant visual supervision. Interview on 2/25/20 with Staff B revealed that client #1 had a door sensor that chimed because he was known to leave his room and go to the rooms of clients #3 and #4, to bite them. Staff B also indicated that client #1 was required to have 1:1 supervision at school but did not have 1:1	W 249		

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supervision at home.

Interview on 2/25/2020, by telephone with the former house manager 2 (HM #2), revealed that client #1 was the known aggressor in the group home. He would target new clients and any client who did not respond to his attacks.

Additional interviews on 2/25/20 with HM #2 revealed that client #2 was supposed to be kept within arm's reach. Client #1 did not have incidents on third shift, since he slept through the night. HM #2 recalled that most of the biting incidents took place on weekends and 2nd shift. Last month, the staff received an in-service regarding supervising client #1 and staff were expected to be "more hands on."

During a phone interview on 2/25/20 with qualified intellectual disabilities professional (QIDP), he relayed that he did not get consistent reports of the number of incidents of client #1 biting or scratching others, but was aware of his history of aggression. On 1/21/20 he received a complaint from client #4's parent, that client #1 had been biting him. QIDP learned that when this incident took place, that staff were on the other side of the house, with other clients.

During another phone interview on 2/25/20 with QIDP, he pointed out at the IPP review last month, the BSP was revised to reflect that spitting was eliminated as a target behavior but that biting was not specifically listed. He did not have a copy of the current BSP on file, but had contacted the psychologist to forward a copy. QIDP shared that he expected his staff to keep up with client #1, especially if he was around others.

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W 249	Continued From page 12 The facility failed to assure adequate interventions and monitoring was provided for client #1 as his BSP did not properly address his behavior or his required supervision appropriately. This active treatment systems failure has caused the facility to fail to ensure the safety of the other clients in the home.	W 249		