PRINTED: 03/18/2020
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	C 03/06/2020

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
W 000	INITIAL COMMENTS A complaint survey was completed on 3/6/2020 for intake #NC00161608. The complaint was substantiated. Deficiencies were cited.	W 000		
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 staff interview, the facility failed to ensure that record keeping was accurate for 2 of 2 clients (#2 and #3) report of injuries. The finding is: 1. Staff did not document all known incidents of client #2's skin injuries. During record review on 3/6/20 for an incident report 1/17/20 for client #2 revealed injuries noted after he arrived home from school. The former home manager recorded that client #3 had marks on his neck and a handprint and marks on his arms, back and face. It was noted that the nurse was notified of the incident. In review of the nurse's monthly note for January 2020, she did not reflect that client #2 had any skin injuries. Interview on 3/6/20 with qualified intellectual disabilities professional (QIDP) confirmed that it was the expectation of the nurse to record accurate skin conditions on the monthly nurse report.	W 111	W.111 This deficiency will be corrected by the following actions: A. All incidents will be reported to management. B. All incidents of unknown origin will be thoroughly investigated. C. Staff will be in serviced on incident reporting documentation D. Staff will be in serviced on reporting incident E. Management will ensure that all incidents have been thoroughly reviewed. F. RN will review all incident reports—and document on incident report G. Management will ensure that all incidents have been reported to all parties. H. Management will immediately investigate any unknown incidents. I. Incident reports will be reviewed monthly.	05.06.2020

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

Jeanne Keung, PMHED — 3/20/2020

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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W 111	Continued From page 1 2. Staff did not document all know incidents of client #3's skin injuries. During record review on 3/6/20 for body audits on 1/10-1/11/20, revealed client #3 bite marks. It was noted that the nurse was notified of the incident. In review of the nurse's monthly note for January 2020, she did not reflect that client #3 had any skin injuries. Interview on 3/6/20 with QIDP confirmed that it was the expectation of the nurse to record accurate skin conditions on the monthly nurse report.	W 111		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to launch a thorough investigation for 1 of 2 audited clients (#2), when presenting an injury of unknown source. The finding is: Facility failed to interview pertinent individuals who had contact with injured client #2 Review on 3/6/20 of client #2's Incident Report dated 1/14/20 at 4:00 pm, revealed that the former Home Manager (HM) recorded that client came home from school on a van. Client had marks on neck on neck and hand print and marks on arms, back and face. Another review on 3/6/20 of a Behavioral Data Sheet on 1/17/20 revealed that client #17 was agitated, yelling and	W 154	W.154 This deficiency will be corrected by the following actions: A. All incidents of unknown origin will be thoroughly investigated. B. Management will ensure that all incidents have been thoroughly reviewed. C. Management will ensure that all incidents have been reported to all parties. D. Management will immediately investigate any unknown incidents. E. Incident reports will be reviewed monthly.	05.06.2020

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W 154	Continued From page 2 aggressive and took 15 minutes to calm down. Interview on 3/6/20 with Staff C revealed that she recalled that the transportation worker claimed that client #2's injuries were due to self-injurious behaviors. Staff C commented that she had never seen any other student on van when client #2 is transported. Staff C reported that client #2's parent was upset and filed a complaint with the school. There was supposed to be a monitor and camera on the bus. Staff C also shared that staff were responsible for recording injuries after doing body audit, before and after school. Staff did not see any injury on client #2 when he left for school on 1/17/20. Interview on 3/6/20 with Qualified Intellectual Disabilities Professional (QIDP) acknowledged that he did not investigate the source of client #2's injury with the school or van driver. The QIDP stated that he got the report from his staff and was told that the parent was following up with the school. The QIDP said that the school was supposed to document incidents, but they never received a report and he did not follow up to inquire. The QIDP speculated that a new driver might have been assigned to transport client #2.	W 154		
W 253	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to record accurate behavioral data	W 253		

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W 253	Continued From page 3 for 2 of 2 audit clients (#2 and #3). The findings is: Staff did not record each behavioral incident on the data logs for clients #2 and #3. a. Review on 3/6/20 of the facility's communication log, reflected that multiple staff recorded client #2's refusal to shower on the following dates: 1/21/20, 1/28/20, 2/11/20, 2/12/20, 2/19/20, 2/26/20, no data was recorded between 2/28-3/2/20 and on 3/3/20. Review of facility's behavioral logs revealed no documentation for client #2 refusing to take showers. Interview on 3/6/20 with Staff C revealed that staff had to do body audits before and after clients attended school. The home manager was responsible for reviewing the documents for monitoring purposes. Since she's been the acting home manager, she has not had a chance to look over the paperwork for a week and wouldn't be surprised if there was missing data. Interview on 3/6/20 with qualified intellectual disabilities professional (QIDP) he relayed that staff have been trained to document all client behaviors on the behavioral log. Once a month, he reviews the logs and includes the numbers of incidents on his monthly QIDP report, which is also reviewed by medical staff for medication consideration. He shared that he was unaware that staff were recording targeted behaviors data in the communication log, because it was not the purpose of the notebook. b. Review on 3/6/20 of the facility's communication log, reflected that multiple staff	W 253	W253 This deficiency will be corrected by the following actions: A. ALL BSP will be reviewed and revised as necessary B. All ISP'S will be reviewed and revise as needed to ensure objectives of BSP is incorporated. C. All current goals will be assessed, modified, update or discontinued to meet needs of consumer. Team will meet and make that decision D. All behavioral objectives will meet the needs of the person being served. E. All behavioral documentation will be reviewed F. All behaviors will be documented G. All staff will be in serviced on recording behavioral documentation H. Residential Manager will monthly weekly I. Clinical Manager will monitor weekly J. BSP will be reviewed monthly at core team	05.06.2020

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W 253	Continued From page 4 recorded client #3's refusal to shower on 2/26/20 and dropping to the floor on 3/3/20, solely on this log. A further review on 3/6/20 of client #3's Behavior Support Plan dated 4/2/19 indicated that he had a targeted behavior of non-compliance and dropping to the floor. Interview on 3/6/20 with qualified intellectual disabilities professional (QIDP) he relayed that staff have been trained to document all client behaviors on the behavioral log. Once a month, he reviews the logs and includes the numbers of incidents on his monthly QIDP report, which is also reviewed by medical staff for medication consideration. He shared that he was unaware that staff were recording targeted behaviors data in the communication log, because it was not the purpose of the notebook.	W 253		

March 19, 2020

Esther Moore, BSW, QIDP
Facility Survey Consultant I
Mental Health Licensure and Certification section
NC Division of Health Services Regulations
2718 Mail Service Center,
Raleigh NC 27699-2718
919.855.3750 office
919.715.8078 fax

RE: **Plan of Correction for Complaint Investigation**
Survey conducted: March 6, 2020
Helmsdale,
1317 Helmsdale Dr. Cary NC 27511
Provider Number 34G253
MHL# 092-107
Complaint Intake NC00161608

Dear Ms. Moore

We appreciate the courtesy extended by you while surveying the **Helmsdale** North Carolina.

As indicated on the Plan of Correction, we will have the Deficiencies corrected for, the Annual survey conducted On **March 6, 2020**, it will be completed **May 6, 2020**

We are committed to providing the highest possible care for the people we serve at **Helmsdale**.

If you have questions, please contact JerMaine Kearney, Program Manager
984.205.2630 ext 403

Sincerely,

JerMaine Kearney, Program Manager/Interim Executive Director
Community Alternatives North Carolina- Southeast Region
1001 Navaho Drive, suite 101
Raleigh, North Carolina, 27609
919.696.5333
984.205.2630 ext. 403
jermaine.kearney@rescare.com