	-	ID HUMAN SERVICES					APPROVED	
		MEDICAID SERVICES). 0938-0391	
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION UDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE COMP	SURVEY	
			A. BUILDI	NG _		с		
		34G253	B. WING				_ 20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				1	317 HELMSDALE DR			
HELMSDA	LE GROUP HOME			C	CARY, NC 27511			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE	
IAG					DEFICIENCY)			
W 000	INITIAL COMMENTS		W	000				
	A complaint and rece	ertification survey was						
		1-4/20/21. Deficiencies						
	were not cited as a re	esult of the complaint survey						
	for Intake #NC00173875. However, the Condition							
	of Participation for Client Behavior and Facility							
		standard level deficiencies						
W/ 100	SERVICES PROVIDE	of the recertification survey.		120				
W 120	SOURCES		vv	120				
	CFR(s): 483.410(d)(3	3)						
		/						
	The facility must assu	are that outside services						
	meet the needs of ea	ch client.						
	This STANDARD is r	not met as evidenced by:						
		iew and interview, the facility						
	failed to ensure outsid	de services met the needs of						
	1 of 4 audit clients (#	6). The finding is:						
	Interview on 1/10/21	with alignst #6's public ashead						
		with client #6's public school nt #6 had been attending						
	school for a few week	0						
		aware of the programs he						
		e facility. She stated she was						
		how independent he was in						
		hing, as this was a need she						
	had identified in the c							
		e had not spoken with the						
		ity since client #6 started						
		ooken with his parents.						
	Review on 4/20/21 of	client #6's individual						
	program plan (IPP) da	ated 3/6/21 revealed he						
		e school. Further review						
	revealed the team ha	-						
	training program to pi	rompt client #6 to brush his						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 04/23/2021

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/23/2021 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G253	B. WING				C 20/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HELMSDA	LE GROUP HOME				1317 HELMSDALE DR CARY, NC 27511		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
W 120	-	sk analysis for 6 months.	w	120			
W 210	and qualified intellect (QIDP) revealed they #6's public school tea to school recently since		w	210	h		
	assessments or reass	admission, the must perform accurate sessments as needed to ninary evaluation conducted					
	Based on record revi failed to ensure the in	ssessments within 30 days affected 3 of 3 newly					
	program plan (IPP) da admitted to the facility of the IPP revealed cl assessments of physi	of client #2's individual ated 1/6/21 revealed he was / on 12/7/20. Further review lient #2 did not have ical therapy, occupational and nutrition in his record.					
	3/1//21 revealed he w 1/29/21. Further revie were not assessment	of client #3's IPP dated vas admitted to the facility on ew of the IPP revealed there is of physical therapy, and psychology in client					

If continuation sheet Page 2 of 19

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/23/2021 MAPPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				(X3) DATE COMP	SURVEY LETED
		34G253	B. WING			-	(04//	<u>)</u> 20/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
HELMSDA	LE GROUP HOME				317 HELMSDALE DR ARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA REFICIENCY)		(X5) COMPLETION DATE
W 210	Continued From page #3's record.	2	w	210				
W 249	3/6/21 revealed he wa 2/6/21. Further review were not assessment occupational therapy, and dental health in c Interview on 4/19/21 of disabilities profession evaluations for clients been completed. PROGRAM IMPLEME CFR(s): 483.440(d)(1 As soon as the interdi formulated a client's in each client must rece treatment program co interventions and serva and frequency to supp objectives identified in plan.	psychology, audiological lient #6's record with the qualified intellectual al (QIDP) revealed these #2, #3 and #6 had not ENTATION) sciplinary team has ndividual program plan, ive a continuous active nsisting of needed vices in sufficient number bort the achievement of the n the individual program	w	249				
		ified in the individual support mplementing behavioral s and medication						
	A. During observation	s in the facility on 4/19/21						

Event ID: SQCY11

Facility ID: 921963

If continuation sheet Page 3 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVE COMPLETED C NAME OF PROVIDER OR SUPPLIER 34G253 B. WING C 04/20/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1317 HELMSDALE DR CARY, NC 27511 C 04/20/20 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH ODRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM COM W 249 Continued From page 3 client #1 began vocalizing, pacing and banging on the walls in the hallway, dining room and living room. The noise of client #1 banging on the walls could be heard from any room in the facility. Staff C was working with client #3 in the kitchen. Staff D and staff E were in the living room with clients #2 and #6. Staff D activated music videos on the living room television for the clients. Staff D called client #1 by name and asked him to sit down but at 5:15pm, client #1 was up pacing and banging on the walls. At one point, staff D called client #1 by name and asked him to sit down but at 5:30pm, client #1 walked into the dining room area and banged on the giass doors of the dining		TMENT OF HEALTH AN RS FOR MEDICARE & I					FORM): 04/23/2021 APPROVED 0. 0938-0391
346253 B. WING	STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HELMSDALE GROUP HOME 1317 HELMSDALE DR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 3 (EACH CORRECTIVE ACTION SHOULD BE COME VW 249 Continued From page 3 W 249 W 249 client #1 became very agitated during meal preparation from 5:00-5:50pm. Client #1 began vocalizing, pacing and banging on the walls in the hallway, dining room and living room. The noise of client #1 banging on the walls could be heard from any room in the facility. Staff C was working with client #3 in the kitchen. Staff D and staff E were in the living room with clients #2 and #6. Staff D activated music videos on the living room television for the clients. Staff D client #1 by name and asked him to sit down but at 5:15pm, client #1 was up pacing and banging on the walls. At one point, staff D took out his personal phone and made a phone call. At 5:30pm, client #1 walked into the dining room area and banged on the glass doors of the dining Att one point, staff D took out his personal phone and made a phone call. At 5:30pm, client #1 walked into the dining room area and banged on the glass doors of the dining			34G253	B. WING		_		
HELMSDALE GROUP HOME 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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM W 249 Continued From page 3 client #1 became very agitated during meal preparation from 5:00-5:50pm. Client #1 began vocalizing, pacing and banging on the walls in the hallway, dining room and living room. The noise of client #1 banging on the walls could be heard from any room in the facility. Staff C was working with client #3 in the kitchen. Staff D and staff E were in the living room with clients #2 and #6. Staff D activated music videos on the living room television for the clients. Staff D called client #1 by name and asked him to sit down but at 5:15pm, client #1 was up pacing and banging on the walls. At one point, staff D took out his personal phone and made a phone call. At 5:30pm, client #1 walked into the dining room area and banged on the glass doors of the dining W 249	NAME OF P	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
(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) COM TAG W 249 Continued From page 3 client #1 became very agitated during meal preparation from 5:00-5:50pm. Client #1 began vocalizing, pacing and banging on the walls in the hallway, dining room and living room. The noise of client #1 banging on the walls could be heard from any room in the facility. Staff C was working with client #3 in the kitchen. Staff D cand staff E were in the living room with clients #2 and #6. Staff D activated music videos on the living room television for the clients. Staff D called client #1 by name and asked him to sit down but at 5:15pm, client #1 was up pacing and banging on the walls. At one point, staff D took out his personal phone and made a phone call. At 5:30pm, client #1 walked into the dining room area and banged on the glass doors of the dining W 249				1	317 HELMSDALE DR			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM IDENTIFYING INFORMATION) W 249 Continued From page 3 client #1 became very agitated during meal preparation from 5:00-5:50pm. Client #1 began vocalizing, pacing and banging on the walls in the hallway, dining room and living room. The noise of client #1 banging on the walls could be heard from any room in the facility. Staff C was working with client #3 in the kitchen. Staff D and staff E were in the living room with clients #2 and #6. Staff D activated music videos on the living room television for the clients. Staff D called client #1 by name and asked him to sit down but at 5:15pm, client #1 was up pacing and banging on the walls. At one point, staff D took out his personal phone and made a phone call. At 5:30pm, client #1 waked into the dining room area and banged on the glass doors of the dining	HELMSDA	ALE GROUP HOME		C	CARY, NC 27511			
client #1 became very agitated during meal preparation from 5:00-5:50pm. Client #1 began vocalizing, pacing and banging on the walls in the hallway, dining room and living room. The noise of client #1 banging on the walls could be heard from any room in the facility. Staff C was working with client #3 in the kitchen. Staff D and staff E were in the living room with clients #2 and #6. Staff D activated music videos on the living room television for the clients. Staff D called client #1 by name and asked him to sit down but at 5:15pm, client #1 was up pacing and banging on the walls. At one point, staff D took out his personal phone and made a phone call. At 5:30pm, client #1 walked into the dining room area and banged on the glass doors of the dining	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
room with such force, the glass vibrated. Staff C raised her voice and told client #1 to "Stop!" Review on 4/20/21 of client #1's behavior support program (BSP) dated 10/13/ 20 revealed he has target behaviors of physical aggression, self-injurious behavior, non-compliance and inappropriately taking food. Further review of this program revealed he has diagnoses of Severe Intellectual Disability, Autism and PICA. Review of the environmental modifications /behavior preventions included: If client #1"is showing signs of agitation or frustration, ask him what is bothering him and try to assist if possible. Simplify the task or assist him in moving the stressor or relocating. Recognize antecedents to behaviors. Intervene to prevent behaviors." Interview on 4/19/21 with staff E revealed that she was relatively new to the facility. She stated sometimes client #1 gets agitated prior to supper. She also explained sometimes when the noise level in the facility was increased, client #1	W 249	client #1 became very preparation from 5:00 vocalizing, pacing and hallway, dining room a of client #1 banging o from any room in the with client #3 in the ki were in the living roor Staff D activated must television for the client by name and asked h 5:15pm, client #1 was the walls. At one poin personal phone and r 5:30pm, client #1 wal area and banged on t room with such force, raised her voice and t Review on 4/20/21 of program (BSP) dated target behaviors of ph self-injurious behavio inappropriately taking program revealed he Intellectual Disability, of the environmental preventions included: of agitation or frustrat bothering him and try Simplify the task or as stressor or relocating, behaviors. Intervene to sometimes client #1 g She also explained so	y agitated during meal 0-5:50pm. Client #1 began d banging on the walls in the and living room. The noise on the walls could be heard facility. Staff C was working itchen. Staff D and staff E m with clients #2 and #6. ic videos on the living room nts. Staff D called client #1 nim to sit down but at is up pacing and banging on nt, staff D took out his made a phone call. At ked into the dining room the glass vibrated. Staff C told client #1 to "Stop!" f client #1's behavior support 10/13/ 20 revealed he has hysical aggression, r, non-compliance and f f cod. Further review of this has diagnoses of Severe Autism and PICA. Review modifications /behavior If client #1"is showing signs tion, ask him what is to assist if possible. ssist him in moving the . Recognize antecedents to to prevent behaviors." with staff E revealed that she the facility. She stated gets agitated prior to supper. ometimes when the noise	W 249				

If continuation sheet Page 4 of 19

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/23/2021 MAPPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G253	B. WING			_		C 20/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HELMSDA	LE GROUP HOME				17 HELMSDALE DR ARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	becomes more agitate interventions in client should verbally redire Interviews on 4/20/21 intellectual disabilities the Program Manage BSP is still current an redirect and relocate of he becomes very agit confirmed direct care their cellphones when in the facility. B. During observation administration on 4/19 #1 sitting next to her, #1's water into a cup, punched Clonidine 0. a cup. Staff C then too disposed of it while cl During observations of on 4/20/21 at 6:18am him, staff G pre poure punched out Flintston mg., Aripiprazole 15m Haldol 2 mg. into a m disposed of client #1's area. Review on 4/19/21 of program plan (IPP) da priority training need for review of the IPP rever	ed. When asked about the #1's BSP, she stated staff ct client #1. with the qualified professional (QIDP) and r (PM) revealed client #1's d direct care staff should client #1 if necessary when ated. Additional interview staff should not be using they are monitoring clients b of medication 0/21 at 4:30pm, with client staff C pre poured client then hand over hand 1 mg. and Haldol 2 mg. into ob client #1's trash and tent #1 left the office area. of medication administration , with client #1 sitting next to d water in a cup, staff G e's Vitamin, Clonidine 0.1 ng., Risperidone 3mg. and edication cup. Staff G is trash as he left the office	W 2	49				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G253	B. WING				C 20/2021	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
HELMSDA	LE GROUP HOME				317 HELMSDALE DR CARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 249	disabilities profession #1's self medication p should be integrated of administration opport PROGRAM MONITO CFR(s): 483.440(f)(3) The committee should monitor individual pro- inappropriate behavior in the opinion of the c client protection and r Based on record revit failed to ensure the re- plans (BSP's) for 4 of and #6) were reviewe human rights committa are: A. Review on 4/19/21 program plan (IPP) da admitted to the facility revealed his adoptive client #2's behalf as h review of client #2's re- behaviors of non-com- aggression, obsessive	o sanitize his hands ation box ation box from the blister pack ash with the qualified intellectual aal (QIDP) confirmed client orogram is still current and during medication unities. RING & CHANGE (i) d review, approve, and ograms designed to manage or and other programs that, committee, involve risks to rights. hot met as evidenced by: iew and interview, the facility estrictive behavior support 4 audit clients (#1, #2, #3 ed and monitored by the tee (HRC). The findings of client #2's individual ated 1/6/21 revealed he was y on 12/7/20. Further review Mom makes decisions on he is a minor. Additional ecord revealed he has target apliance and physical e compulsive disorder and	W :					
	attention deficit disord	-						

Facility ID: 921963

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PRINTED: 04/23/2021

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/23/2021 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G253	B. WING			C 04/20/2021		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
HELMSDA	LE GROUP HOME				317 HELMSDALE DR CARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
W 262	Continued From page	9 6	w	262				
	dated 3/30/21 revealed	client #2's physician orders ed he receives Risperidone 2 ng. and Clonidine 0.1 mg.						
	revealed he does not committee (HRC) rev	iew or approval for the use Divalproex 250 mg. and						
	3/1/21 revealed he wa 1/29/21 with a diagno of client #3's record re	of client #3's IPP dated as admitted to the facility on sis of Autism. Further review evealed he is in the legal ment of Social Services in						
	orders dated (3/27/21	client #3's physician's) revealed he receives bex 25 mg., Divalproex afacine 3 mg., and						
	revealed the facility de approval for the use	9/21 of client #3's record oes not have HRC review or of Abilify 5 mg., Divalproex odium 25 mg., Guanfacine 3 e 5 mg.						
	Autism, Seizure Disor Processing Disorder.	itted to the facility on w revealed he has te Intellectual Disability,						

Facility ID: 921963

If continuation sheet Page 7 of 19

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/23/2021 MAPPROVED). 0938-0391	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G253	B. WING		_	C 04/20/2021		
NAME OF PF	ROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
HELMSDA	LE GROUP HOME			317 HELMSDALE DR				
				CARY, NC 27511				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 262	Continued From page	7	W 262					
	dated 3/16 21 revealed mg ER at am and at m Divalproex 250 mg. tw Risperidone 2 mg. at Further review on 4/19 revealed the facility de approval of Clonidine night for impulsivity, E daily for mood and Ris D. Review on 4/19/21 8/13/20 revealed he h Intellectual Disabilities review revealed his pa for him as he is a min Review on 4/19/21 of revealed he receives daily for mood/behavi Further review on 4/20/21 of revealed the facility de approval of the use of Interview on 4/20/21 v intellectual disabilities the Program Manager does not have HRC re use of client #1, #2, # medications. Further i management was away	vice daily for mood and bedtime for aggression. 9/21 of client #6's record bes not have HRC review or 0.1 mg ER at am and at Divalproex 250 mg. twice speridone 2 mg. of client #1's IPP dated has diagnoses of Severe s, PICA and Autism. Further arents make legal decisions or. his physician orders 3/30/21 Clonidine 0.1 mg. four times or. 0/21 of client #1's record bes not have HRC review or f Clonidine for client #1. with the the qualified professional (QIDP) and r (PM) confirmed the facility eview or approval for the 3 and #6's psychotropic interview revealed are that HRC had not						
W 263		and had not followed up onsultant to ensure this was RING & CHANGE	W 263					

Facility ID: 921963

If continuation sheet Page 8 of 19

	-	D HUMAN SERVICES					FORM	04/23/2021	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· /		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G253	B. WING			_		C 20/2021	
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
HELMSDA	LE GROUP HOME				1317 HELMSDALE DR CARY, NC 27511				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 263	are conducted only wi	(ii) d insure that these programs ith the written informed parents (if the client is a	w	263					
	Based on record revir failed to ensure restric conducted with the wr legal guardian. This a (#1, #2, #3 and #6). T A. Review on 4/19/21 program plan (IPP) da admitted to the facility	not met as evidenced by: ew and interview, the facility ctive programs were only ritten informed consent of a affected 4 of 4 audit clients The findings are: of client #2's individual ated 1/6/21 revealed he was y on 12/7/20. Further review Mother makes decisions on							
	review of client #2's re behaviors of non-com	e compulsive disorder and							
	(dated 3/30/21) revea	client #2's physician orders led he receives Risperidone) mg. and Clonidine 0.1 mg. y.							
	revealed written inform Risperidone 2 mg., Di	9/21 of client #2's record med consent for the use of valproex 250 mg. and ended release was not lity							
	3/1/21 revealed he wa	of client #3's IPP dated as admitted to the facility on sis of Autism. Further review							

Facility ID: 921963

If continuation sheet Page 9 of 19

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	: 04/23/2021 APPROVED . 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
	34G253	B. WING		_	04/2	; 20/2021
NAME OF PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HELMSDALE GROUP HOME			1317 HELMSDALE DR CARY, NC 27511			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
custody of the Departm Guilford County. Review on 4/19/21 of co orders dated (3/27/21) Abilify 5 mg., Divalproe Sodium 25 mg., Guanf Hydroxyzine 5 mg. dail Further review on 4/19, revealed the facility dou informed consent for th Divalproex 25 mg., Div Guanfacine 3 mg., and C. Review of client #6's revealed he was admit 2/26/21. Further review diagnoses of Moderate Autism, Seizure Disord Processing Disorder. A his parents make legal he is a minor. Review on 4/19/21 of co dated 3/16 21 revealed mg ER at am and at nig Divalproex 250 mg. twi Risperidone 2 mg. at b Further review on 4/19, revealed the facility doo informed consent for th ER at am and at night	vealed he is in the legal hent of Social Services in client #3's physician's revealed he receives ex 25 mg., Divalproex acine 3 mg., and y. /21 of client #3's record es not have written he use of Abilify 5 mg., alproex Sodium 25 mg., Hydroxyzine 5 mg. s IPP dated 3/6/21 ted to the facility on v revealed he has e Intellectual Disability, fer and Sensory additional review revealed decisions on his behalf as client #6's physician orders he receives Clonidine 0.1 ght for impulsivity, ice daily for mood and edtime for aggression. /21 of client #6's record es not have written he use of Clonidine 0.1 mg for impulsivity, Divalproex mood and Risperidone 2	W 263				

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	-	D HUMAN SERVICES					FORM): 04/23/2021 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
		34G253	B. WING _			_		C 20/2021
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HELMSDA	LE GROUP HOME				317 HELMSDALE DR ARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 263	Intellectual Disabilities review revealed his pa for him as he is a min Review on 4/19/21 of revealed he receives daily for mood/behavi Further review of clier	has diagnoses of Severe s, PICA and Autism. Further arents make legal decisions or. his physician orders 3/30/21 Clonidine 0.1 mg. four times or. ht #1's record revealed the	W 2	263				
W 266	the use of client #1's of Interview on 4/20/21 of disabilities profession Manager (PM) revealed obtained written inforr #2, #3 and #6 use of p Further interview with management staff did psychology consultant completed. CLIENT BEHAVIOR & CFR(s): 483.450 The facility must ensu- behavior and facility p met. This CONDITION is n The facility failed to: i antecedents of 1 of 4 inappropriate behavior intervene appropriate techniques used to m	with the qualified intellectual al (QIDP) and the Program ed the facility has not med consent for clients #1, psychotropic medications. the PM revealed I not follow up with the t to ensure this was & FACILITY PRACTICES are that specific client bractices requirements are not met as evidenced by: identify possible audit clients (#6)'s or triggers and failed to ly (W268), assure that all	W 2	266				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/23/2021 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G253	B. WING		_	(04/:	C 20/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HELMSDA	LE GROUP HOME			317 HELMSDALE DR CARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 266	inappropriate behavio integral part of the clie that is directed specifi of and eventual elimin which the drugs are e The cumulative effect resulted in the facility' statutorily mandated (Practices. CONDUCT TOWARD CFR(s): 483.450(a)(1) These policies and pro- growth, development client. This STANDARD is n Based on observation interviews, the facility possible antecedents inappropriate behavio intervene appropriate agitated The finding .During observations from 3:15pm-7:00pm, facility was increased activated music video #1, #2 and #6 in the li client #6 was rocking couches near the wind	at drugs used for control of r were used only as an ent's individual program plan cally towards the reduction hation of the behaviors for mployed (W312). of these systemic practices s failure to provide Client Behavior and Facility CLIENT)(i) ocedures must promote the and independence of the not met as evidenced by: ns, record review and staff failed to identify of 1 of 4 audit clients (#6)'s r triggers and failed to ly when he became is: in the facility on 4/19/21 the noise level in the as staff D and staff E had s on television for clients ving room area. At 4:55pm, one of the living room dow back and forth was rocking back and forth	W 266		DEFICIENCY)		
	vibrating the living roc	om floor so that the couch ow. He was not redirected					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		34G253	B. WING				_ 20/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
HELMSDALE GROUP HOME					I317 HELMSDALE DR CARY, NC 27511		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 268	Review on 4/19/21 of he was admitted to th	e 12 ho were in the living room. client #6 's record revealed le facility on 2/26/21. Further as diagnoses of Moderate	w	268			
	Intellectual Disability, and Sensory Process	Autism, Seizure Disorder ing Disorder. There was not ogram (BSP) in client #6's					
	dated 3/16 21 reveale mg ER at am and at r Divalproex 250 mg. tv	client #6's physician orders ed he receives Clonidine 0.1 hight for impulsivity, wice daily for mood and bedtime for aggression.					
W 288	redirect client #6 when Interview on 4/20/21 of revealed client #6 door should be redirected of Further interview comb becomes agitated wh room is increased and decrease background MGMT OF INAPPRO BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manag	en the noise level in the d staff should try to d noise whenever possible. PRIATE CLIENT	w	288			
	Based on observatio	not met as evidenced by: n, record review and failed to ensure a technique					

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PRINTED: 04/23/2021

		D HUMAN SERVICES					FORM	028 0201
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	LETED
		34G253	B. WING			_		C 20/2021
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HELMSDA	LE GROUP HOME				317 HELMSDALE DR CARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 288	Continued From page to manage client #1's included in an active to affected 1 of 4 audit of During observations in 6:45am, staff A assist bag and jacket in prep facility to go outside to school. Staff A told cli and prompted him to Client #1 rolled over of floor. Staff A and staff to give up his head ph to his tablet. Twice, st headphones and said so we can go to schoo up and walk. After abo outside and signaled to go ahead and leave vehicle had pulled aw and sat on the couch headphones which we Client #1 got up from later and went into his door. Interview on 4/20/21 of Review on 4/20/21 of	A 13 inappropriate behavior was treatment plan. This lients(#1). The finding is: In the facility on 4/20/21 at ed client #1 with his book paration for leaving the p his transportation to ent #1 his ride was outside get up and go with him. In the couch and onto the H attempted to get client #1 nones that were connected aff reached for client #1's , "Give me the head phones ol." Client #1 refused to get but 9 minutes, staff A went to the transportation driver e. After the transportation ay outside, client #1 got up briefly listening to his ere connected to his tablet. the couch about 20 minutes a bedroom and shut the with staff A and the RM) revealed client #1 was at day and they would go to school the following		288				
	program (BSP) dated target behaviors of ph self-injurious behavior inappropriately taking program revealed he	10/13 20 revealed he has						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/23/2021 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G253	B. WING		_	04/2	C 20/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HELMSDA	ALE GROUP HOME			1317 HELMSDALE DR CARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 288	of the environmental in preventions included: signs of agitation or fr bothering him and try Simplify the task or as stressor or relocating. behaviors. Intervene f Review of the BSP re- procedures involving headphones for non-or Interview on 4/20/21 v disabilities profession BSP is current and sta #1's belongings but st DRUG USAGE CFR(s): 483.450(e)(2 Drugs used for contro- must be used only as client's individual prog specifically towards the elimination of the beh are employed. This STANDARD is r Based on record revis failed to ensure drugs inappropriate behavior integral part of an action directed towards the r behaviors for which the This affected 3 of 4 and The findings are: A. Review on 4/19/21	modifications /behavior If client #1 "is showing ustration, ask him what is to assist if possible. ssist him in moving the Recognize antecedents to to prevent behaviors." vealed there were no removing client #1's compliance. with the qualified intellectual al (QIDP) confirmed the aff should not remove client hould follow his BSP	W 288				

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-		D HUMAN SERVICES					FORM): 04/23/2021 MAPPROVED
STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	ES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	LETED
		34G253	B. WING			_		C 20/2021
NAME OF PROVIDER OR S	SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HELMSDALE GROUP	НОМЕ				317 HELMSDALE DR CARY, NC 27511			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
admitted t of client # behaviors aggressio attention of Review or dated 3/30 mg., Dival extended Further re revealed r address th psychotro Interview of disabilities Manager (a BSP to a which he r medication managem program h failed to fo B. Review or orders dat Abilify 5 m Sodium 25 Hydroxyzi	2's record re of non-com n, obsessive deficit disord a 4/20/21 of 0/21 reveale proex 250 r release. view on 4/1 no behavior ne inappropi pic medication (PM) confirm address the receives sev ns. Further i ent was aw ad not been of 4/19/21 of ealed he was ith a diagno a 4/19/21 of ed (3/27/21 ng., Divalpro 5 mg., Guar ne 5 mg. view on 4/1 no BSP to a	v on 12/7/20. Further review evealed he has target pliance, physical e compulsive disorder and	W	312				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/23/2021 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G253	B. WING			_		C 20/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HELMSDALE GROUP HOME					1317 HELMSDALE DR CARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 312	Continued From page receives.	9 16	w	31	2			
	confirmed client #3 do address the inapprop receives several psyc Further interview reve aware a behavior sup	ealed management was port program had not been they failed to follow up to						
	C. Review of client #6 revealed he was adm 2/26/21. Further revie diagnoses of Moderat Autism, Seizure Disor Processing Disorder.	itted to the facility on w revealed he has te Intellectual Disability,						
	dated 3/16 21 revealed mg ER at am and at r Divalproex 250 mg. tw Risperidone 2 mg. at Further review on 4/1 revealed no BSP to a behaviors for the psyc	client #6's physician orders ed he receives Clonidine 0.1 hight for impulsivity, vice daily for mood and bedtime for aggression. 9/21 of client #6's IPP ddress the inappropriate chotropic medication he						
W 340	confirmed client #6 do address the inapprop receives several psyc Further interview reve aware a behavior sup developed however, ensure this was comp	ealed management was port program had not been they failed to follow up to pleted.	w	34	0			

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/23/2021 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í				(X3) DATE COMP	SURVEY LETED
		34G253	B. WING			_		C 20/2021
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HELMSDA	LE GROUP HOME				317 HELMSDALE DR CARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 340	Continued From page		w	340				
	CFR(s): 483.460(c)(5)(i)						
	other members of the appropriate protective measures that include	t include implementing with interdisciplinary team, and preventive health b, but are not limited to aff as needed in appropriate ethods.						
	Based on observation review, nursing service team failed to ensure adequate hygiene relation mandated by facility p pandemic of COVID-1	not met as evidenced by: n, interview and record ses and the interdisciplinary staff were trained to assure ative to wearing masks as policy during a state wide 19. This affected 6 of 6 , #5 and #6). The finding is:						
	3:30pm-7pm, staff D r 4:30pm while he was his cellphone in the liv living room area for a next to clients #2, #4 about the facility into the where staff C and clie	n the facility on 4/19/21 from removed his mask around making a personal call on ving room. He sat in the period of about 45 minutes and #5. Staff D also moved the dining room and kitchen int #6 were working on meal im. Staff D put his mask and nose at 5:18pm.						
	6:05pm staff D remov while he was in the liv	on 4/19/21 after supper at ed his mask below his chin ring room with clients #4, #5 his mask over his face at						
		the facility's pandemic h was attached to their revealed there were						

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/23/2021 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G253	B. WING			_		C 20/2021
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
HELMSDALE GROUP HOME					317 HELMSDALE DR CARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 340	disease in the facility. Interview on 4/19/21 of disabilities profession pandemic policy requised facility wear a facial m and mouth. Interview on 4/20/21 of (PM) revealed staff and	t transmission of infectious with the qualified intellectual al (QIDP) revealed the ires all staff working in the nask that covers their nose with the program manager re to wear facial masks at all with clients due to the state	W	340				

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