STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G,	COMPLETED
					C
	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	34G253	B, WING _		04/20/2021
NAME OF PI	ROVIDER OR SUPPLIER		; ;	STREET ADDRESS. CITY, STATE, ZIP CODE	
HELMSDA	LE GROUP HOME			1317 HELMSDALE OR	
				CARY, NC 27511	
(X4) ID		ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		Y'MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)	, m.m.
	,	•		DEFICIENCY)	
	M				
W 000	INITIAL COMMENTS		. W or	on!	
	A complaint and rece	rification augustus			
		1-4/20/21. Deficiencies			
		sult of the complaint survey	1		
		375. However, the Condition	j		
		ent Behavior and Facility	1		
		tandard level deficiencies			
		of the recertification survey.	ĺ		
W 120		· · · · · · · · · · · · · · · · · · ·	W 12	20	
** 'mv	SOURCES	was Editi ma Calman		i (	
	CFR(s): 483.410(d)(3	1	į	W. 120	
		,	f	A. Qualified person will re	view all 6/4/2021
	The facility must assu	re that outside services		ISP's	
	meet the needs of ea		-	B. Residential Manager ar	nd Clinical
			1	Supervisor will ensure t	hat there
			İ	contact is made and th	at there is
	This STANDARD is r	ot met as evidenced by:		intercommunication be	tween
	Based on record revi	ew and interview, the facility	;	the group home and s	chools.
		services met the needs of		physicians, therapists, o	etc. in
	1 of 4 audit clients (#6	6). The finding is:	1	order to ensure outside	e services
1				meet the needs of the	consumer
		with client #6's public school		. C. Site Supervisor will mo	nitor this
		nt #6 had been attending		weekly	
	school for a few week			D. Qualified Professional	will ·
		aware of the programs he	i	monitor this monthly	1
		facility. She stated she was now independent he was in			Į.
		ing, as this was a need she		•	•
	had identified in the c				•
		had not spoken with the		•	
		ty since client #6 started	1	· · ·	4
	•	ocken with his parents.	!	•	;
	•			;	:
	Review on 4/20/21 of	client #6's individual			•
		ated 3/6/21 revealed he	:	:	
		school. Further review	1 1		•
	revealed the Jeam had			:	
	training program to pr	ompt client #6 to brush his			•
		MONITOR OF THE PROPERTY OF THE			( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )
IBUKATURY (	JINEU JUNS OR PROVIDER/S	OPPLIER REPRESENTATIVE'S SIGNATUR	Eq.	Malaca TITLE 1/11 - 1000	(X6) DATE
·	/ // INM st	A / B / LII	MAN	INCHICAN INIBANIDA	<u> 4174101)</u>
w deficie jity	statement enough which	lerisk (*) denotes a deficient which the	and Hation may	be excused from correcting providing it is determine	d that
ioi salgijuar	ds provide sufficient protection	on to the patients (See instructions.) Ex	cept for nursing	homes, the findings stated above are disclosable 9	0 days
owing the di	ate of survey whether or not We date these documents of	a plan of correction is provided. For num is made available to the facility. If deficis	sing nomes, the ancies are cited	above findings and plans of correction are disclosal an approved plan of correction is requisite to contin	неd
og/am partic				21 min the same of same and in a addition of a same of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X3) DATE SURVEY COMPLETED	
	34G253	B. WING	· · · · · · · · · · · · · · · · · · ·	C 04/20/2021
NAME OF PROVIDER OR SUPPLIER HELMSDALE GROUP HOME			STREET ADDRESS. CITY, STATE, ZIP CODE 1317 HELMSDALE DR CARY, NC 27511	, 07202021
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
· very	k analysis for 6 months.	W 12	0 W. 210	
and qualified intellect (QIDP) revealed they #6's public school tea to school recently sin- INDIVIDUAL PROGR CFR(s): 483.440(c)(3  Within 30 days after a interdisciplinary team assessments or reass supplement the prelin prior to admission.  This STANDARD is r Based on record revi failed to ensure the in performed accurate a after admission. This admitted audit clients findings are:  A. Review on 4/19/21 program plan (IPP) da admitted to the facility of the IPP revealed cl assessments of physi therapy, psychology a  B. Review on 4/19/21 3/11/21 revealed he w	admission, the must perform accurate sessments as needed to ninary evaluation conducted not met as evidenced by: ew and interview the facility terdisciplinary team seessments within 30 days affected 3 of 3 newly (#2, #3 and #6). The of client #2's individual ated 1/6/21 revealed he was on 12/7/20, Further review ient #2 did not have call therapy, occupational and nutrition in his record.	W 21	This deficiency will be the following actions:  A. Management w	vill ensure that pral support place upport plans d. upport Plans current nique to ropriate niques will be behaviors I review all sional will hin guardian sional will BSP gned by HRC inservice on pport Plans imentation. Inger will e a week

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A: BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		34G253	B. WING	:			C
NAME OF B	ROVIDER OR SUPPLIER	390233				04	/20/2021
NAME OF E	KOVIDER OR SOFFLIER	• •	1.	STREET ADDRESS, CITY,	STATE, ZIP CODE		
HELMSDA	ALE GROUP HOME	1 94		1317 HELMSDALE DR	•	;	at a like in the St
			<u></u>	CARY, NC 27511	<del></del>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTIC RECTIVE ACTION SHOULI RENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
111.540							
W 210	Continued From page	e 2	W 210	) .			
	#3's record.						
	O D	d and address states as a	į				
		1 of client #6's IPP dated as admitted to the facility on			*		
		w of the IPP revealed there		1			<b>.</b>
	s	ts of physical therapy;	:				; ;
	occupational therapy	, psychology, audiological			•	•	
	and dental health in o	dient #6's record	1				
					•		
		with the qualified intellectual national (QIDP) revealed these		ļ.,			:
		s #2, #3 and #6 had not				•	,
	been completed.	a semi no ana na manta					
W 249	PROGRAM IMPLEM	ENTATION	W 249	1	•		
	CFR(s): 483.440(d)(1	· ·					;
i				1			
	As soon as the interd						
		ndividual program plan, ive a continuous active		•			·
	treatment program co	The second secon	:	:	•	•	
		vices in sufficient number	i .	•		•	
		port the achievement of the				;	
	•	n the individual program	1	1			
	plan.			1			
:							·
:		•					
	This STANDARD is r	not met as evidenced by:	•				
		ns, record review and				•	
		failed to ensure 1 of 4					
	treatment program co	received a continuous active			•		,
;		ified in the individual support			•		
		implementing behavioral					
	intervention strategies	s and medication					
	administration progra	ms. The findings are:					
:	A Dual	is in the facility on 4/19/21	,			,	
	A. During observation	is in the facility of 4/19/21					

	OF DEFICIENCIES . CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	*	LETED
		240000	B.WING				
		34G253	S. VAIDAGE			1 ; 04/	20/2021
NAME OF PROVIDER OR SUPPLIER ** HELMSDALE GROUP HOME			1.49	13	rreet address, city, state, zip code 117 Hèlmsdale Dr ARY, NC 27511	<b>Æ</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTING (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	0 8E	(X5) COMPLETION DATE
W 249	preparation from 5:00 vocalizing, pacing and hallway, dining room of client #1 banging of from any room in the with client #3 in the killwere in the living roor Staff D activated must felevision for the clier by name and asked h 5:15pm, client #1 was the walls. At one poin personal phone and room with such force, raised her voice and Review on 4/20/21 of program (BSP) dated target behaviors of ph self-injurious behavior inappropriately taking program revealed he Intellectual Disability, of the environmental preventions included: of agitation or frustrat bothering him and try Simplify the task or a stressor or relocating behaviors. Intervene Interview on 4/19/21 was relatively new to sometimes client #1 or	y agitated during meal 1-5:50pm. Client #1 began d banging on the walls in the and living room. The noise in the walls could be heard facility. Staff C was working tchen. Staff D and staff E in with clients #2 and #6. ic videos on the living room its. Staff D called client #1 im to sit down but at is up pacing and banging on it, staff D took out his nade a phone call. At ked into the dining room the glass doors of the dining the glass vibrated. Staff C told client #1 to "Stop!"  client #1's behavior support 10/13/ 20 revealed he has hysical aggression, in, non-compliance and food. Further review of this has diagnoses of Severe Autism and PICA. Review modifications /behavior If client #1"is showing signs ion, ask him what is to assist if possible. sisist him in moving the Recognize antecedents to to prevent behaviors."	W	249	W 249 This deficiency will be corrected following actions:  A. The Area Supervisor and Supervisor will be respondered for in-servicing the state continuous active treated and revised to ensure that all object met  C. Staff will be in-serviced ISP's and BSP's  D. All people served will be afforded the opportune as independent as post independent in it is being in it is it it is	nd the Site consible ff on tment. be as needed ctives are if on the oe sible ite nical onsible ekly and ng done. vill vhile	* ,
		ometimes when the noise		:			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT (	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A, BUILDING	E CONSTRUCTION	2	(X3) DATI COM	E SURVEY PLETED	
• • • • •		34G253	. B. WING		·	04	/20/2021	
	NAME OF PROVIDER OR SUPPLIER HELMSDALE GROUP HOME			STREET ADDRESS, CITY, 1317 HELMSDALE DR CARY, NC 27511	STATE, ZIP CODE			
(X4) ID PREFIX TAG	· (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION).	ID PREFIX TAG	PROVIDE (EACH COR	R'S PLAN OF CORRECTI RECTIVE ACTION SHOUL RENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
W 040			141.546		,			
W 249	Continued From pa		W 249					
		tated. When asked about the ent #1's BSP, she stated staff irect client #1.						
-		21 with the qualified ies professional (QIDP) and					' 	
	the Program Mana 8SP is still current	ger (PM) revealed client #1's and direct care staff should	٠			÷	!	
	he becomes very a	te client #1 if necessary when igitated. Additional interview ire staff should not be using	-		•			
	their cellphones when the facility.	ien they are monitoring clients						
	#1 sitting next to he #1's water into a cu punched Clonidine a cup. Staff C then	ions of medication /19/21 at 4:30pm, with client er, staff C pre poured client up, then hand over hand 0.1 mg, and Haldol 2 mg, into took client #1's trash and e client #1 left the office area.						
		s of medication administration						
	him, staff G pre po- punched out Flints	am, with client #1 sitting next to ured water in a cup, staff G tone's Vitamin, Clonidine 0.1	·					
	Haldol 2 mg. into a disposed of client #	5mg., Risperidone 3mg. and medication cup. Staff G f1's trash as he left the office						
	area.		1					
	program plan (IPP) priority training nee review of the IPP re medication with 75	of client #1's individual dated 8/13/20 revealed a d for self medication. Further evealed a program for self accuracy for 6 consecutive	·				· ·	
	months implement	ed on 10/1/19. The steps			•	4		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLEA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING			COMI	(X3) DATE SURVEY COMPLETED			
		34G253	B. WING	•			C /20/2021
	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, 1317 HELMSDALE DR CARY, NC 27511	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPR DEFICIENCY)	8E	(Xb) COMPLETION DATE
W 249	Continued From page 1) Require client #1 to	o sanitize his hands	W 24				
ı	2) Point to his medica 3) Remove his medic 4) Punch out his pills 5) Throw away his tra	ation box from the blister pack				,	
W 262	disabilities profession #1's self medication p should be integrated administration opport	unities. RING & CHANGE	W 26	12			
	monitor individual pro inappropriate behavio	d review, approve, and grams designed to manage or and other programs that, ommittee, involve risks to lights.	:	:			
:	Based on record revi failed to ensure the re plans (BSP's) for 4 of and #6) were reviewe	not met as evidenced by: iew and interview, the facility estrictive behavior support 4 audit clients (#1, #2, #3 d and monitored by the iee (HRC), The findings					
	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	compulsive disorder and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUC	TION	(X3) DATE SURVEY	
AND PLAN OF	F CORRECTION .	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		34G253	B. WING		C 04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	V - +++++++++++++++++++++++++++++++++++	STREET ADDR	RESS, CITY, STATE, ZIP CODE	<u> </u>
UELMOD	N E COOLO DONE		1317 HELMS	DALE DR	
HELMODA	ALE GROUP HOME		CARY, NC	27511	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B IOSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
· · · · · · · · · · · · · · · · · · ·	Review on 4/20/21 of dated 3/30/21 revealed mg., Divalproex 250 extended release.  Further review on 4/1 revealed he does not committee (HRC) revof Risperidone 2 mg. Clonidine 0.1 mg. ext. B. Review on 4/19/21 3/1/21 revealed he w 1/29/21 with a diagnoof client #3's record recustody of the Depart Guilford County.  Review on 4/19/21 of orders dated (3/27/21	client #2's physician orders ad he receives Risperidone 2 ng. and Clonidine 0.1 mg.  9/21 of client #2's record have human rights iew or approval for the use Divalproex 250 mg. and ended release.  of client #3's IPP dated as admitted to the facility on sis of Autism. Further review evealed he is in the legal liment of Social Services in  client #3's physician's ) revealed he receives lex 25 mg., Divalproex	W. 262 This de the foll A. B. C. D. E.	DEFICIENCY)	il by 6/4/2021 e that ort lans lans all be ors all
	revealed the facility of approval for the use 25 mg., Divalproex S mg., and Hydroxyzine C. Review of client #6 revealed he was adm 2/26/21. Further reviewing roses of Modera Autism, Seizure Diso Processing Disorder.	is IPP dated 3/6/21 litted to the facility on w revealed he has te intellectual Disability,	l. J.	consent.  Qualified Professional whave consented BSP reviewed and signed by representative  All staff will be in-service all Behavioral Support Pland proper documentat Residential Manager will monitor one time a wee Qualified Professional whomitor this weekly	ill HRC on lans ion. I

W/1m/14 ( lm) (	O I OI ( III D) OTHE O	MEDIONIO SERVICES						CHILD IA	), U0000-U00 i		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING					(XS) DATE SURVEY COMPLETED		
,		*							c		
	· , , , , , , , , , , , , , , , , , , ,	34G253	B. WING					04	20/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CI	TY, STATE, ZIP CODI		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1		
			1	1317 HE	LMSDALE DI	R			, .		
HELMSDA	ALE GROUP HOME	•		CARY,	NC 27511		* .	٠, ٠			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<del></del>	<del></del>		DER'S PLAN OF CO	MCTIONI	<u> </u>	(X5)		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX	1		DRRECTIVE ACTION		E '	COMPLETION		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	1	CROSS-RE	FERENCED TO THE.	APPROPRIA	NTE	DATE		
						DEFICIENCY)	/		Ì		
	<b>₹</b> `		· !	5							
W 262	Continued From page	<b>₹</b> 7	W 26	32							
	:	•			•						
	Review on 4/19/21 of	client #6's physician orders	;						i		
	dated 3/16 21 reveals	ed he receives Clonidine 0.1									
	mg ER at am and at r	night for impulsivity,				100			,		
	Divalproex 250 mg. to	vice daily for mood and		1					•		
	Risperidone 2 mg, at	bedtime for aggression.		•					:		
			•			•					
	Further review on 4/1	9/21 of client #6's record							•		
,	revealed the facility d	oes not have HRC review or									
		0.1 mg ER at am and at					•		,		
		Divalproex 250 mg, twice	•						•		
	daily for mood and Ri	speridone 2 mg.	' ·						!		
		of client #1's IPP dated									
		nas diagnoses of Severe									
		s, PICA and Autism. Further									
:		arents make legal decisions									
	for him as he is a min	or.						,			
	Daviou on 4/10/21 of	his physician orders 3/30/21					•				
		Clonidine 0.1 mg. four times									
	daily for mood/behavi			1				:			
	· · · · · · · · · · · · · · · · · · ·	500 t									
	Further review on 4/2	0/21 of client #1's record									
		oes not have HRC review or									
		f Clonidine for client #1.									
4		•									
	Interview on 4/20/21 v	with the the qualified									
		professional (QIDP) and									
		r (PM) confirmed the facility	•			•					
,		eview or approval for the				•					
		3 and #6's psychotropic									
	medications. Further i										
	management was awa				**						
		and had not followed up									
		onsultant to ensure this was									
	completed.										
W 263	PROGRAM MONITO	RING & CHANGE	W 26	3							

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/23/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	(S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
1	•		1 .	•	· c		
, , ,		34G253	B. WING		04/20/2021		
NAME OF P	PROVIDER OR SUPPLIER		5"	TREET ADDRESS, CITY, STATE, ZIP CODE			
· · · · · · · · · · · · · · · · · · ·	AT IN AMALIN LIMILE	*	I	317 HELMSDALE OR			
HEFWORK	ALE GROUP HOME	· .	1 '	ARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
*******	5		, , , , , , , , , , , , , , , , , , ,	W. 263	·		
W 263	Continued From page		W 263	This deficiency will be corrected	ed by 6/4/2021		
•	· CFR(s): 483.440(f)(3)	)(ii)	:	the following actions:	ea by		
	The committee shoul	ld insure that these programs		1			
	are conducted only w	vith the written informed	•	A. Management will ensu			
,		parents (if the client is a		current behavioral sup	port .		
	minor) or legal guardi	lan.	.:	plan are put in place	•		
		, ,	•	B. All behavioral support	plans		
	weeks a security of them, at you you by	4 6		will be reviewed.	r		
v.		not met as evidenced by:		C. All Behavioral Support	: Plans		
		riew and interview, the facility ictive programs were only		will address the curren			
•		ritten informed consent of a		needs and technique t			
		affected 4 of 4 audit clients	,	manager inappropriate			
	(#1, #2, #3 and #6).			behavior			
	And the company of th	Tegan memeri dan memer		D. All proper techniques v	ا عظ الأنما		
	and the second s	of client #2's individual		used to manage behav			
		ated 1/6/21 revealed he was		E. Psychologist will review	a.		
		y on 12/7/20. Further review		plans.	V cm		
		Mother makes decisions on					
		he is a minor, Additional		F. HRC approval and the			
:		record revealed he has target		consents will be obtain	ied for j		
	behaviors of non-com	npliance and physical re compulsive disorder and		all BSP's	,		
	aggression, obsessive attention deficit disord			G. Qualified Professional v			
	audinon worms	<b>16</b> 1.	•	review and obtain gua	rdian		
	Review on 4/20/21 of	f client #2's physician orders		consent.			
	(dated 3/30/21) revea	aled he receives Risperidone	•	H. Qualified Professional v	vill		
	2 mg., Divalproex 250	0 mg. and Clonidine 0.1 mg.		have consented BSP			
	Extended release dail			reviewed and signed by	y HRC		
		· · · · · · · · · · · · · · · · · · ·		representative			
		9/21 of client #2's record		<ol> <li>All staff will be in-servic</li> </ol>	e on		
		med consent for the use of		all Behavioral Support i			
		livalproex 250 mg. and tended release was not		and proper documenta			
	obtained from the faci			J. Residential Manager wi			
	VUIGNICH HOM HIC MIL	inty		monitor one time a wee			
	B. Review on 4/19/21	of client #3's IPP dated		K. Qualified Professional v			
		as admitted to the facility on		monitor this weekly	****		
		-		man medal of the antifaction			

1/29/21 with a diagnosis of Autism. Further review

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUSC	TIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER;	A. BUILDI		COMPLETED
		34G253	B. WING		04/20/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	**************************************
HELMSDA	ALE GROUP HOME		<u> </u>	1317 HELMSDALE DR CARY, NC 27511	$\mathcal{D}_{i}(\mathcal{E}_{i}) = \frac{1}{i} \mathcal{E}_{i}(\mathcal{E}_{i}) \cdot \mathbf{e}$
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLETION
W 263	Continued From page	. 0		000	
		evealed he is in the legal	VV 2	263	•
		Iment of Social Services in			
	Tamora Dounty.				•
		f client #3's physician's		:	: ·
		l) revealed he receives			•
	Ability 5 mg., Divalpro	oex 25 mg., Divalproex			
	Sodium 25 mg., Guar Hydroxyzine 5 mg. da				
	Further review on 4/1	9/21 of client #3's record			1
	revealed the facility d	oes not have written		•	:
		the use of Abilify 5 mg.,			i
	Divalproex 25 mg., D Guanfacine 3 mg., ar	ivalproex Sodium 25 mg., nd Hydroxyzine 5 mg.			4
	C. Review of client #6				
	revealed he was adm				•
	2/26/21. Further revie				
	Autism, Seizure Disor	te Intellectual Disability,			
	Processing Disorder. his parents make lega	Additional review revealed at decisions on his behalf as			
•	he is a minor.	·			
	Review on 4/19/21.of	client #6's physician orders			
		ed he receives Clonidine 0.1	,		•
	mg ER at am and at r			•	
		vice daily for mood and bedtime for aggression.			
		9/21 of client #6's record			
	revealed the facility de				
		the use of Clonidine 0.1 mg for impulsivity, Divalproex			
		r mood and Risperidone 2		•	
	mg.	ייניים אול איל אל לייניים איניים br>מייניים איניים איני	•		
	D. Review on 4/19/21	of client #1's IPP dated			,

ED: 04/23/2021 RMAPPROVED IO. 0938-0391	FOF	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					
re survey MPLETED	CONSTRUCTION (X3) DAT	(X2) MULTIPLE A. BUILDING	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NT OF DEFICIENCIES I OF CORRECTION	STATEMENT		
C 4/20/2021		B. WING	34G253				
ALTONOM .	REET ADDRESS, CITY, STATE, ZIP CODE	· s	NAME OF PROVIDER OR SUPPLIER				
	17 HELMSDALE OR ARY, NC 27611	-1		DALE GROUP HOME	HELMSD		
(X5) COMPLETION DATE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	ID PREFIX TAG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	( EACH DEFICIENC	(X4) ID PREFIX TAG		
		. W 263		3 Continued From page	W 263		
* , *	•		as diagnoses of Severe s, PICA and Autism. Further arents make legal decisions or.	Intellectual Disabilitie			
		: :	his physician orders 3/30/21 Clonidine 0,1 mg, four times or.	Review on 4/19/21 of revealed he receives daily for mood/behavi			
		' '	t #1's record revealed the written informed consent for Clonidine.	Further review of clier facility does not have the use of client #1's to			
			ned consent for clients #1, sychotropic medications. the PM revealed not follow up with the	disabilities profession Manager (PM) reveald obtained written inforr			
6/4/2021	W. 266 This deficiency will be corrected by the following actions:  A. Staff will be in-serviced on all BSP's B. Staff will be trained on all proper techniques to managed behavior C. Stie Supervisor will monitor this weekly D. Qualified Professional will monitor this weekly	W 266	actices requirements are  of met as evidenced by: lentify possible udit clients (#6)'s triggers and failed to (W268), assure that all	CLIENT BEHAVIOR & CFR(s): 483.450  The facility must ensure behavior and facility primet.  This CONDITION is in The facility failed to: in antecedents of 1 of 4 a inappropriate behavior intervene appropriately.			
	This deficiency will be corrected by the following actions:  A. Staff will be in-serviced on all BSP's  B. Staff will be trained on all properties to managed behavior  C. Stie Supervisor will monitor this weekly  D. Qualified Professional will	W 266	written informed consent for Clonidine.  with the qualified intellectual all (QIDP) and the Program and the facility has not need consent for clients #1, sychotropic medications. The PM revealed not follow up with the to ensure this was  FACILITY PRACTICES  That specific client actices requirements are  of met as evidenced by: lentify possible udit clients (#6)'s triggers and failed to (W268), assure that all nage behaviors are	facility does not have the use of client #1's of the use of t			

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PRINTEO: 04/23/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 34G253 B. WING 04/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 1317 HELMSDALE DR **HELMSDALE GROUP HOME CARY, NC 27511** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLEYION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 11 W 266 (W288) and assure that drugs used for control of inappropriate behavior were used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed (W312). The cumulative effect of these systemic practices. resulted in the facility's failure to provide statutorily mandated Client Behavior and Facility Practices. W 268 | CONDUCT TOWARD CLIENT W 268 CFR(s): 483.450(a)(1)(i) W. 268 This deficiency will be corrected by These policies and procedures must promote the growth, development and independence of the the following actions: client. A. Staff will be in-serviced on all This STANDARD is not met as evidenced by: BSP's Based on observations, record review and Staff will be trained on all proper interviews, the facility staff failed to identify techniques to managed possible antecedents of 1 of 4 audit clients (#6)'s behavior inappropriate behavior triggers and failed to · C. Stie Supervisor will monitor this intervene appropriately when he became weekly agitated.. The finding is: D. Qualified Professional will monitor this weekly .During observations in the facility on 4/19/21 from 3:15pm-7:00pm," the noise level in the facility was increased as staff D and staff E had activated music videos on television for clients #1, #2 and #8 in the living room area. At 4:55pm. client #6 was rocking one of the living room couches near the window back and forth

vocalizing loudly. He was rocking back and forth so forcefully that the legs of the couch were vibrating the living room floor so that the couch rocked near the window. He was not redirected

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		34G253	B. WING_		C 04/20/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/20/2021		
		·		1317 HELMSDALE DR	v		
HELMSDA	ALE GROUP HOME	·	,		1 *** *		
232				CARY, NC 27511	1 2 2 41 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
W 260	Continued Store make	. 30					
. YY ZOO	Continued From page		W 2	168	<b>\$</b>		
	by staff D or staff E w	ho were in the living room.	,		<u> </u>		
•	i (m)				• • •		
•		client #6 's record revealed			•		
		e facility on 2/26/21. Further			ì		
		as diagnoses of Moderate		1			
		Autism, Seizure Disorder ing Disorder. There was not	ļ.		<b>`</b>		
		ogram (BSP) in client #6's	. !	;	;		
	record.	ogram (bor) in client #0\$	,	•			
•	, 1000141		•,		•		
		client #6's physician orders d he receives Clonidine 0.1 aight for impulsivity.	;		: ;		
	Divalproex 250 mg. tv	vice daily for mood and bedtime for aggression.			,		
,	Interview on 4/19/21 v	with staff D revealed they	:		•		
		n he becomes very agitated.		•			
		es not have a BSP but when he becomes agitated.			1		
:	Further interview confi			W. 288	6/4/2021		
	_	en the noise level in the		This deficiency will be corr	ected by		
	room is increased and	•		<sup>1</sup> the following actions:			
	-	noise whenever possible.					
W 288	MGMT OF INAPPROP BEHAVIOR		W 28	BSP's  A. Staff will be in-service	ed on all		
	CFR(s): 483.450(b)(3)			B. Staff will be trained o			
	Techniques to manage	inappropriate client		techniques to manag	lea		
		e used as a substitute for		behavior	onitor this		
	an active treatment pro	ogram,		<ul> <li>C. Stie Supervisor will m weekly</li> </ul>	,		
	Based on observation	ot met as evidenced by: , record review and siled to ensure a technique		<ul> <li>D. Qualified Professiona monitor this weekly</li> </ul>	il will		

PRINTED: 04/23/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 34G253 8. WING 04/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1317 HELMSDALE DR **HELMSDALE GROUP HOME CARY, NC 27511** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S FLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) W 288 Continued From page 13 W 288 to manage client #1's inappropriate behavior was included in an active treatment plan. This affected 1 of 4 audit clients(#1). The finding is: During observations in the facility on 4/20/21 at 6:45am, staff A assisted client #1 with his book bag and jacket in preparation for leaving the facility to go outside to his transportation to school. Staff A told client #1 his ride was outside and prompted him to get up and go with him. Client #1 rolled over on the couch and onto the floor. Staff A and staff H attempted to get client #1 to give up his head phones that were connected to his tablet. Twice, staff reached for client #1's headphones and said, "Give me the head phones so we can go to school." Client #1 refused to get up and walk. After about 9 minutes, staff A went outside and signaled to the transportation driver to go ahead and leave. After the transportation vehicle had pulled away outside, client #1 got up and sat on the couch briefly listening to his headphones which were connected to his tablet. Client #1 got up from the couch about 20 minutes later and went into his bedroom and shut the door. Interview on 4/20/21 with staff A and the residence manager (RM) revealed client #1 was going to stay home that day and they would attempt to get him to go to school the following day.

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	(X3) DAYE SURVEY COMPLETED			
· ,		34G253	B. WING	C 04/20/2021		
NAME OF PROVIDER OR SUPPLIER HELMSDALE GROUP HOME			,	STREET ADDRESS, CITY, STATE, ZIP CODE 1317 HELMSPALE DR CARY, NC 27511	1 0412012021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
W 288	of the environmental preventions included: signs of agitation or fit bothering him and try Simplify the task or astressor or relocating behaviors, intervene Review of the BSP reprocedures involving headphones for non-fit	modifications /behavior  If client #1 "is showing rustration, 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	W 288			
	#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 th		- <b>W</b> 312			
	Based on record revifailed to ensure drugs inappropriate behavio integral part of an actidirected towards the ribehaviors for which the This affected 3 of 4 au. The findings are:  A. Review on 4/19/21	not met as evidenced by: ew and interview, the facility used for the control of rs were used only as an ve treatment program eduction or elimination of the drugs were employed. udit clients (#2, #3 and #6).  of client #2's individual thed 1/6/21 revealed he was				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI	(X3) DATE SURVEY COMPLETED	
			c		
		34G253	B. WING		04/20/2021
NAME OF P	RÖVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	:
HELMSDALE GROUP HOME				317 HELMSDALE OR CARY, NC 27511	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECT	TION (SS)
PREFIX TAG	(EACH DEFICIE	NCY MUST SE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE COMPLETION
W 312	Continued From pa		W 312	W. 312 This deficiency will be correcte	d by the
	admitted to the facility on 12/7/20. Further review of client #2's record revealed he has target behaviors of non-compliance, physical			following actions:	6/4/2021
•		Bive compulsive disorder and			
	attention deficit dis	order.		A. Management will en	
	:			current behavioral se	• •
i		of client #2's physician orders		plan are put in place	
		aled he receives Risperidone 2		<ul> <li>B. All behavioral suppo</li> </ul>	rt plans į
	· · ·	0 mg. and Clonidine 0,1 mg.	• .	will be reviewed.	
	extended release.			<ul> <li>C. All Behavioral Suppo</li> </ul>	ort Plans
e ·	Cinth and an electric and a	(40)04fb		will address the curr	ent ·
;		l/19/21 of client #2's IPP or support program (BSP) to		needs and technique	e to
		or support program (65F) to opriate behaviors for the		manager inappropri	ate
	psychotropic medic			behavior	,
	,	,		D. All proper technique	es will be
:	Interview on 4/21/2	1 with the qualified intellectual		used to manage bel	naviors
	disabilities professi	onal (QIDP) and Program		E. Psychologist will rev	
,	Manager (PM) confirmed client #2 does not have			plans.	
	a BSP to address the inappropriate behaviors for			F. HRC approval will be	<b>3</b>
	which he receives several psychotropic			obtained for all BSP	
		er interview revealed		psychotropic medica	
		ware a behavior support		G. Qualified Profession	at will
		en developed however, they bensure this was completed.		review and obtain g	1
				consent.	
		21 of client #3's IPP dated		H. Qualified Profession	al will
		was admitted to the facility on		have consented BSP	
	1/29/21 with a diagr	nosis of Autism.		reviewed and signed	· · · · · · · · · · · · · · · · · · ·
	Review on 4/19/21	of client #3's physician's		representative	
	Review on 4/19/21 of client #3's physician's orders dated (3/27/21) revealed he receives			I. All staff will be in-ser	vice on
	Abilify 5 mg., Divalproex 25 mg., Divalproex			all Behavioral Suppo	1
	Sodium 25 mg., Guanfacine 3 mg., and		•	and proper docume	
	Hydroxyzine 5 mg.	Ments of the		J. Residential Manager	
	,				
	Further review on 4	/19/21 of client #3's IPP		monitor one time a	
		address the inappropriate		K. Qualified Profession	ai wiii
	behaviors for the ps	ychotropic medication he		monitor this weekly	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  34G253			1 " '	IPLE CONSTRI	UCTIÓN	•		(X3) DATE SURVEY COMPLETED	
		•	A, BUILOING			<b>944</b>	1	c	
		8. WING			<del></del>	.  - 04	/20/2021		
NAME OF PROVIDER OR SUPPLIER					STATE, ZIP CODE				
HELMSDALE GROUP HOME			4	1317 HELMSDALE DR CARY, NC 27511			* . '	1944 BAS + 1 197	
(X4) ID PREFIX TAG	(EACH DEFIÇIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORR	'S PLAN OF CORRECT ECTIVE ACTION SHOU ENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
W 312	Continued From page	o 16		12					
	receives.					٠,		, :	
	* ** ****** ** ******** * * * * * * *								
,	Interview on 4/21/21	with the QIDP and PM		1.4		'			
;	confirmed client #3 do			1		31.7		,	
	, , ,	riate behaviors for which he		•					
,	receives several psyc		•						
		ealed management was port program had not been				, v		,	
		they failed to follow up to						:	
	ensure this was comp				•			-	
	C. Review of client #6	S's IPP dated 3/6/21	1					1	
!	C. Review of client #6's IPP dated 3/6/21 revealed he was admitted to the facility on 2/26/21. Further review revealed he has diagnoses of Moderate Intellectual Disability, Autism, Seizure Disorder and Sensory								
			,				. *		
						· ·	•		
;						-			
,	Processing Disorder.	,		•	•	,			
,	Decidence as AMOIDA of	. Ha at MCta who sieles a suday			•	,			
		client #6's physician orders ed he receives Clonidine 0.1							
,	mg ER at am and at r						•	,	
		vice daily for mood and							
	-	bedtime for aggression.		1					
	,	· ,				•			
	Further review on 4/1					· ·	1	1	
		ddress the inappropriate					`		
	receives.	chotropic medication he							
	Interview on 4/21/21 v	with the OIDD and Oth	-					,	
•	confirmed client #6 do								
•		address the inappropriate behaviors for which he receives several psychotropic medications.							
		aled management was					,	1	
	aware a behavior support program had not been							1	
		they failed to follow up to			*			1	
	ensure this was comp	leted.							
W 340	NURSING SERVICES	` ·	w 3	40	•				
		,							

#### PRINTED: 04/23/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER; A. BUILDING C B. WING 34G253 04/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1317 HELMSDALE DR **HELMSDALE GROUP HOME CARY, NC 27511** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) (X4) (D ID. COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL! TEACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 6/4/2021 W 340 Continued From page 17 W 340 CFR(s): 483.460(c)(5)(i) W. 340 Nursing services must include implementing with This deficiency will be corrected by the other members of the interdisciplinary team, following actions: appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate A. The nurse will be responsible for health and hygiene methods. in-servicing all members of the interdisciplinary team, on the This STANDARD is not met as evidenced by: use of appropriate protective Based on observation, interview and recordand preventive health measures, review, nursing services and the interdisciplinary which include, but not limited to team failed to ensure staff were trained to assure trainings clients, and staff as adequate hygiene relative to wearing masks as needed in appropriate health mandated by facility policy during a state wide and hygiene methods, following pandemic of COVID-19. This affected 6 of 6 COVID protocol by wearing clients (#1, #2, #3, #4, #5 and #6). The finding is: surgical masks at all times while working in the home. During observations in the facility on 4/19/21 from The nurse will monitor this 3:30pm-7pm, staff D removed his mask around monthly 4:30pm while he was making a personal call on The Site Supervisor will monitor his cellphone in the living room. He sat in the this weekly living room area for a period of about 45 minutes D. The Qualified Professional will next to clients #2, #4 and #5. Staff D also moved monitor this weekly. about the facility into the dining room and kitchen where staff C and client #6 were working on meal preparation from 5-6pm. Staff D put his mask back over his mouth and nose at 5:18pm. During observations on 4/19/21 after supper at 6:05pm staff D removed his mask below his chin while he was in the living room with clients #4, #5 and #6. He adjusted his mask over his face at

Review on 4/19/21 of the facility's pandemic policy (undated) which was attached to their emergency plan (EP) revealed there were

6:15pm,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  34G253		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED C 04/20/2021	
		8. WING					- 1		
* .	ROVIDER OR SUPPLIER			1317 HE	ADDRESS, CIT LMSDALE DR NC 27511		CODE		
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W 340	Continued From pag	e 18	. Wa	340					
	procedures to preve disease in the facility	nt transmission of infectious		:	,		•		† : : : :
	disabilities professio pandemic policy req	with the qualified intellectual nal (QIDP) revealed the uires all staff working in the mask that covers their nose				۶	•		
	. (PM) revealed staff a	with the program manager are to wear facial masks at all with clients due to the state of COVID-19.		·					
	:		:	•		,			¢ , , , , , , , , , , , , , , , , , , ,
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1001 Navaho Dr., Suite 101 Raleigh, NC 27609 PHONE: (919)387-1011 FAX: (919)387-1130





To: KIM MC/ARKILL	From: Tranka Jallian
Fax: (919) 715-9078	Pages: (including cover)
Phone:	Date 1/29/2021
Re: HUMANIA SULVAN POL	cc:
☐ Urgent ☐ For Review ☐ Please Comme	ent ☐ Please Reply ☐ Please Recycle

April 30, 2021

Kim McCaskill
Facility Consultant 1
Mental Health Licensure & Certification Section
2718 Mail Service Center
Raleigh, NC 27699-2718
919.218.9152 M
919.715.8078 F

Re: Survey Completed April 13, 2021 Helmsdale Group Home 1317 Helmsdale Drive Cary, NC 27511 Provider Number 34G253 MHL# -092-107

Dear Mrs. McCaskill

We appreciate the courtesy extended by you while surveying the Helmsdale Group Home, North Carolina.

As Indicated the Plan of Correction, we have will have the deficiencies corrected for the Annual Survey Conducted on April 20, 2021 it will be completed by June 4, 2021.

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

If you have any questions, please contact Cynthia Bradford, Associate Executive Director at 984.205.2630 ext. 238.

Kind Regards,

Cynthia Bradford, Associate Executive Director
Community Alternatives North Carolina- Raleigh Region
1001 Navaho Drive, suite 101
Raleigh, NC, 27609
276.252.8193
984.205.2630 ext. 403
Cynthiabradford@rescare.com