Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	COMPLET			
		MHL042-086	B. WING		07/1	9/2021		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HELPING HANDS MH/DD SERVICES, LLC 317 WASHINGTON AVENUE WELDON, NC 27890								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
V 000 INITIAL COMMENTS			V 000					
	on 7/19/21. The co	iplaint survey was completed mplaint was unsubstantiated 26. A deficiency was cited.						
	categories: 10A NC Rehabilitation Facil Severe and Persist 27G .4400 Substar Program & 10A NC	sed for the following CAC 27G .1200 Psychosocial ities for Individuals with ent Mental Illness; 10A NCAC ace Abuse Intensive Outpatient AC 27G .4500 Substance sive Outpatient Treatment						
V 113	27G .0206 Client R	ecords	V 113					
	(a) A client record sindividual admitted contain, but need n (1) an identification (A) name (last, first (B) client record nu (C) date of birth; (D) race, gender ar (E) admission date (F) discharge date; (2) documentation developmental disadiagnosis coded ac (3) documentation assessment; (4) treatment/habilit (5) emergency inforshall include the nanumber of the persudden illness or a and telephone numphysician;	face sheet which includes: , middle, maiden); mber; and marital status;						

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

(X6) DATE TITLE

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		MIII 0 40 000	B. WING		0=/4	0/0004		
		MHL042-086	<u> </u>		07/1	9/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
HELPING HANDS MH/DD SERVICES, LLC 317 WASHINGTON AVENUE WELDON, NC 27890								
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	emergency care from (7) documentation (8) documentation (9) if applicable: (A) documentation diagnosis according of Diseases (ICD-9 (B) medication order (C) orders and copic (D) documentation administration error (b) Each facility sharelative to AIDS or only in accordance	granting permission to seek om a hospital or physician; of services provided; of progress toward outcomes; of physical disorders g to International Classification -CM); ers; ies of lab tests; and	V 113					
	failed to ensure doctoward outcomes we (#1 & #2) records. Review on 7/19/21 - admitted 1/20/2 - diagnoses of D Depressive Disorde - last documente was January 2021 Review on 7/19/21 - admitted 10/21	view and interview the facility cumentation of progress vere in 2 of 3 audited clients. The findings are: of client #1's record revealed: 21 iabetes, Hypertension & Major er ed service notes in the record of client #2's record revealed:						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL042-086	B. WING		07/1	9/2021	
NAME OF PROVIDER OR SUPPLIER HELPING HANDS MH/DD SERVICES, LLC STREET ADDRESS, CITY, STATE, ZIP CODE 317 WASHINGTON AVENUE WELDON, NC 27890							
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V 113	During interview on Professional/Directe - the clients' servite achers' computer - the teachers we have access to the - when she (QP/I teachers, she wrote gave them to the te - the teacher conthe end of the week name (teacher nam - if she could chaprogram, it would be service notes During interview on reported: - she would ensured.	7/19/21 the Qualified or (QP/Director) reported: vice notes were saved in the sere not available and she didn't service notes Director) filled in for the exthe service notes down and eacher appleted weekly notes and at act, the teacher would sign her	V 113				

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