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

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY LETED		
		34G253	B. WING	ING _			
		340233	2			05/	16/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HELMSD	ALE GROUP HOME				17 HELMSDALE DR ARY, NC 27511		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX T		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPROPRIATE	LD BE	COMPLETION DATE
E 039			E 0		Deficiency E039 will be corrected by complet following:	ing the	7/15/2023
	§460.84(d)(2), §482. §483.475(d)(2), §484 §485.542(d)(2), §485 §485.920(d)(2), §491 *[For ASCs at §416.6 §485.542, OPO, "Org CMHCs at §485.920, ESRD Facilities at §4 (2) Testing. The [facitest the emergency pld o all of the followin (i) Participate in a full community-based events (A) When a community-based events (B) If the [facility man-made emergency plan, the in its next required confacility-based function of the actual event. (ii) Conduct an addity years, opposite the years opposite the years of the paraginal of the pa	2) 113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), .102(d)(2), §485.68(d)(2), .625(d)(2), §494.62(d)(2)12(d)(2), §494.62(d)(2)54, CORFs at §485.68, REHs at ganizations" under §485.727, .RHCs/FQHCs at §491.12, and 194.62]: .Itity] must conduct exercises to an annually. The [facility] must g: .It-scale exercise that is				f an annual exercise or ired by gency Il emergency f drill when	
	(A) A second full-sca community-based or functional exercise; or (C) A tabletop exercise	individual, facility-based or (B) A mock disaster drill; ise or workshop that is led by					
ABORATORY	DIRECTOR'S OR PROVIDED	VSUPPLIER REPRESENTATIVE'S SIGNATUR	F		TITLE		(X6) DATE

Monica Flarrel son, MSW, MPA Program Manager 5/28/25

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

OMB NO. 0938-0391

If continuation sheet Page 1 of 18

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.

Facility ID: 921963

Event ID:M0ZM11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1 2	(X3) DATE SURVEY COMPLETED	
		34G253	B. WING		05/	16/2023	
	ALE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1317 HELMSDALE DR CARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIA	OULD BE	(X5) COMPLETIC DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

				OMB 140. 0750-0571
039	Continued From page 1 a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise	E 039	Please see page 1 of 19.	7/15/2023
	that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using			
STATEMENT PLAN OF CO	OF DEFICIENCIES AND (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	34G253	B. WING		05/16/2023
NAMEOF	PROVIDER OR SUPPLIER		TREET ADDRESS, CITY, STATE, ZIP CODE	03/10/2023
	PROVIDER OR SUPPLIER DALE GROUP HOME	1	317 HELMSDALE DR CARY, NC 27511	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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a narrated, clinically- a set of problem state prepared questions demergency plan. (3) Testing for hospidirectly. The hospid the emergency plan to the following: (i) Participate in an acommunity-based; or (A) When a community-based; or accessible, conduct a functional exercise; or natural or man-made activation of the emergency from engagin	relevant emergency scenario, and ements, directed messages, or esigned to challenge an ces that provide inpatient care e must conduct exercises to test wice per year. The hospice must annual full-scale exercise that is	E 039	Please see page 1 of 19.	7/15/2023
following the onset of Conduct an additions include, but is not ling second full-scale exertacility based function (B) A mock distriction (C) A tabletope facilitator that include narrated, clinically-set of problem states prepared questions of emergency plan. (iii) Analyze the holdocumentation of all	of the emergency event. (ii) al annual exercise that may mited to the following: (A) A ercise that is community-based or a			
ATEMENT OF DEFICIENCIES AND AN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DATE

CARY, NC 27511

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PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

HELMSDALE GROUP HOME

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SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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

OMB NO. 0938-0391

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	exercises to test the exercises to test the exercises to test the exercise; of the community-based; or accessible, conduct a functional exercise; of the community based or activation of the emergency event. (ii) Conduct and that may include, but (A) A second furctional exercise; of the community-based or functional exercise; of the community-based or	.184(d), Hospitals at §485.625(d):] TF, Hospital, CAH] must conduct emergency plan twice per year. , CAH] must do the following: annual full-scale exercise that is munity-based exercise is not annual individual, facility-based or f, Hospital, CAH] experiences an annual emergency that requires ergency plan, the [facility] is ng in its next required full-scale individual, facility-based ollowing the onset of the [additional] annual exercise or and it is not limited to the following: ll-scale exercise that is individual, a facility-based or ester drill; or exercise or workshop that is led by udes a group discussion, using a elevant emergency scenario, and a ments, directed messages, or lesigned to challenge an emergency e [facility's] response to and tion of all drills, tabletop exercises, its and revise the [facility's] needed.		
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OMB NO. 0938-0391

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

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	exercises to test the exercises to test the exercises to test the exercise in an acommunity-based; or (A) When a commaccessible, conduct an functional exercise; of (B) If the PACE man-made emergency emergency plan, the It its next required full-individual, facility-bathe onset of the emergency (ii) Conduct an acopposite the year the under paragraph (d) (2) that may include, but (A) A second full-secommunity-based or functional exercise; or (C) A tabletop exercifacilitator and include narrated, clinically-reacted a set of problem state prepared questions defended and maintain docume exercises, and emergency plan. (iii) and maintain docume exercises, and emergency plan. (For LTC Facilities)	E organization must conduct mergency plan at least annually. on must do the following: nnual full-scale exercise that is munity-based exercise is not annual individual, facility-based rexperiences an actual natural or that requires activation of the PACE is exempt from engaging in scale community based or sed functional exercise following gency event. dditional exercise every 2 years full-scale or functional exercise exercise every 2 is not limited to the following: ale exercise that is individual, a facility based or (B) A mock disaster drill; is e or workshop that is led by a sea group discussion, using a levant emergency scenario, and ments, directed messages, or esigned to challenge an Analyze the PACE's response to notation of all drills, tabletop ency events and revise the lan, as needed.			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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	Continued From page	5				
	test the emergency pla	an at least twice per year,				
		ed staff drills using the				
		s. The [LTC facility, ICF/IID]				
	must do the following					
		nnual full-scale exercise that is				
	community-based; or					
		nunity-based exercise is not				
		n annual individual, facility-based				
	functional exercise.	and the state of t				
		acility] facility experiences an made emergency that requires				
		gency plan, the LTC facility is				
		g its next required a full-scale				
		individual, facility-based				
		llowing the onset of the				
		Conduct an additional annual				
		ude, but is not limited to the				
		ond full-scale exercise that is				
community-based or an individual, facility based						
		r (B) A mock disaster drill; or				
		ercise or workshop that is led by				
		group discussion, using a	=			
		levant emergency scenario, and a				
		ents, directed messages, or				
	emergency plan.	signed to challenge an				
		C facility] facility's response to				
		ntation of all drills, tabletop		21		
		ency events, and revise the				
		's emergency plan, as needed.				
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,, F,				
	*[For ICF/IIDs at §48	33.475(d)]:				
	(2) Testing. The ICF/	IID must conduct exercises to test				
	the emergency plan a					
	The ICF/IID must do	The state of the s				
	(i) Participate in an ar	nnual full-scale exercise that				
	1					
STATEMENT PLAN OF CO	OF DEFICIENCIES AND	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE	SURVEY
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HELMSI	DALE GROUP HOME			CARY, NC 27511		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

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	community-based; or				
	(A) When a comm	nunity-based exercise is not			
		annual individual, facility-			
	based functional exerc				
		experiences an actual natural or			
		that requires activation of the CF/IID is exempt from engaging			
		l-scale community-based or			
		sed functional exercise following			
	the onset of the emerg				
		onal annual exercise that may			
		ited to the following: (A) A			
		cise that is community-based ty-based functional exercise;			
	or (B) A mock disaste				
	(C) A tabletop exercis	e or workshop that is led by a			
	facilitator and include	s a group discussion, using a			
		evant emergency scenario, and			
		nents, directed messages, or			
	prepared questions de	signed to challenge an Analyze the ICF/IID's response			
		nentation of all drills, tabletop			
		ncy events, and revise the			
	ICF/IID's emergency				
	*[For HHAs at §484.]				
		HA must conduct exercises to			
		an at least annually. The HHA			
	must do the following				
	community-based; or	l-scale exercise that is			
	,	mmunity-based exercise is not			
		an annual individual, facility-			
		cise every 2 years; or.			
STATEMENT	OF DEFICIENCIES AND	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MILTI	PLE CONSTRUCTION	(X3) DATE SURVEY
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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 039			E 039	Please see page 1 of 19.		7/15/2023
E 039	man-made emergency emergency plan, the I- its next required full-s individual, facility bas the onset of the emerg (ii) Conduct an accomposite the year the it under paragraph (d)(2 that may inch following: (A) A second full community-based or a functional exercise; or (B) A mock disas (C) A tabletop ex a facilitator and include narrated, clinically-re- set of problem statem- prepared questions de plan. (iii) Analyze the I- documentation of all of	experiences an actual natural or that requires activation of the atha is exempt from engaging in scale community-based or sed functional exercise following gency event. Idditional exercise every 2 years, full-scale or functional exercise (i) of this section is conducted, ade, but is not limited to the escale exercise that is an individual, facility-based of the exercise or workshop that is led by des a group discussion, using a levant emergency scenario, and a cents, directed messages, or signed to challenge an emergency ethal's response to and maintain drills, tabletop exercises, and	E 039	Please see page 1 of 19.		7/15/2023
	emergency events, and plan, as needed. *[For OPOs at §486.3] (d)(2) Testing. The Othe emergency plan. The Country of the emergency plan. The emergency plan. The emergency plan is a paper-busy at least annuly a facilitator and invariant of the emergency plan. The emergency plan is a plan in the emergency plan is a plan in the emergency plan. The emergency plan is a plan in the emergency plan is a plan in the emergency plan in the emergency plan is a plan in the emergency plan in the emergency plan is a plan in the emergency plan in the emergency plan is a plan in the emergency plan in the emergency plan in the emergency plan is a plan in the emergency plan	d revise the HHA's emergency				
STATEMENT	OF DEFICIENCIES AND	(XI) PROVIDER/SUPPLIER/CLIA			(X3) DATE	SURVEY
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	ALE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1317 HELMSDALE DR CARY, NC 27511		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIATE D	D BE	(X5) COMPLETION DATE

E 039			E 039	7/15/2023
E 039	If the OPO experience made emergency that emergency plan, the in its next required to onset of the emergen response to and main tabletop exercises, and the [RNHCI's and Onneeded. *[RNCHIS at §403.3 (d)(2) Testing. The Fitest the emergency p following: (i) Conduct a pleast annually. A tab discussion led by a fic clinically-relevant emproblem statements,	o challenge an emergency plan. ces an actual natural or man- it requires activation of the OPO is exempt from engaging esting exercise following the ncy event. (ii) Analyze the OPO's ntain documentation of all nd emergency events, and revise PO's] emergency plan, as 748]: RNHCI must conduct exercises to lan. The RNHCI must do the aper-based, tabletop exercise at letop exercise is a group acilitator, using a narrated, nergency scenario, and a set of directed messages, or prepared	E 039	7/15/2023
	clinically-relevant er problem statements, questions designed to (ii) Analyze the maintain documentate emergency events, as plan, as needed. This STANDARD is on document review to ensure a full scale tabletop activity was	nergency scenario, and a set of		
	Review on 5/15/23 of there was no annual	Iness Plan (EP). The finding is: of the facility's EP Plan revealed tabletop conducted. Further se, mock drill or annual tabletop		
			Please see page 1 of 19.	
ATEMENT	OF DEFICIENCIES AND	(X1) PROVIDER/SUPPLIER/CLIA		Larn name a
AN OF COR		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
		34G253	B WING	

STATEMENT C PLAN OF CORI	OF DEFICIENCIES AND RECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 34G253	A (X2) MULT A. BUILDIN B. WING	BUILDING COM WING		E SURVEY PLETED
	OVIDER OR SUPPLIER ALE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1317 HELMSDALE DR CARY, NC 27511		
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E 039					J. 0938-0391
W 189	Continued From page During an interview Supervisor (AS) conhave documentation their EP plan. STAFF TRAINING CFR(s): 483.430(e)(The facility must proand continuing trainiperform his or her decompetently. This STANDARD is Based on observation interviews, the facility sufficiently trained in clients (#3) during must be competently. During dinner observation interviews, the facility sufficiently trained in clients (#3) during must be competently. This STANDARD is Based on observation interviews, the facility sufficiently trained in clients (#3) during must be clients (#3) during must be competently. Staff A was wrist while he was attempting to push 5:15pm, Staff A was #3's wrist while he at mouth. During an immediate stated he was "being the fact he will put to because he eats very interview with Staff giving too much physical staff and the s	on 5/15/23, the Area firmed the facility EP did not detailing any exercises to test PROGRAM I) ovide each employee with initial ing that enables the employee to aties effectively, efficiently, and is not met as evidenced by: ins, document review and by failed to ensure staff were in a technique to assist 1 of 3 audit eals. The finding is: vations in the home on 5/15/23 at observed grabbing client #3's tempting to lift the spoon to his rvations revealed Staff A wrist ten times, while client #3 this spoon into his mouth. At observed pushing down on client tempted to lift his spoon to his einterview on 5/15/23, Staff A physical" with client #3 due to no much food into his mouth fast and might choke. Further A revealed he realized he was sical touch with client #3. If client #3's Occupational tion (no date) revealed, "Pt.	W 189	Deficiency W189 will be corrected by completing the following: A. Team will ensure the completion of training centered around mealtimes. DSPs will be inserviced on proper hand over hand techniques without use of force. B. QIDP and site supervisor to complete mealtime observations. C. Team will consult with OT to address mealtime guidelines and use of adaptive equipment if applicable. D. QIDP to monitor monthly. E. Area Supervisor and/or Site Supervisor to monitor twice a month.	7/15/2023
STATEMENT	OF DESIGNATION AND	(VI) PROVIDED			
PLAN OF COR	OF DEFICIENCIES AND RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G253	A. BUILDING	E CONSTRUCTION (X3) DATE COMP	E SURVEY LETED
MANGAGE	DAUIDER OF CLIENT	340233		05/	16/2023
NAME OF P	ROVIDER OR SUPPLIER		1 200	TREET ADDRESS, CITY, STATE, ZIP CODE	
	ALE GROUP HOME		1	317 HELMSDALE DR CARY, NC 27511	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL C 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 189			W 189	Please see page 11 of 19.	7/15/2023
W 210	During an interview (AS) stated client #3 slow down his rate of assistance only. INDIVIDUAL PROCEFR(s): 483.440(c)(Within 30 days after team must perforeassessments as preliminary evaluation record review and obtain needed initial clients (#2, #3 and #4. A. Review on 5 revealed he had not refurther review revealed he had not revealed he had not refurther review revealed he had not	on 5/16/23, the Area Supervisor should have been prompted to of eating with hand over hand	W 210	Deficiency W210 will be corrected by confollowing: A. Team will ensure the completion or reassessments within 30 days admission. B. Team will ensure that all outstar appointments are completed. C. RN will ensure communication for doctors' appointments that a schedule. D. QIDP to monitor monthly. E. RN to monitor twice a month. F. Area Supervisor and/or Site Supmonitor twice per month.	n of assessments of a new adding and assistance re hard to
STATEMENT PLAN OF COR	OF DEFICIENCIES AND RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G253	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED

STATEMENT PLAN OF COR	OF DEFICIENCIES AND RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G253	(X2) MULTI A. BUILDIN B. WING	LDING		E SUR VEY PLETED
NAME OF PROVIDER OR SUPPLIER HELMSDALE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP 1317 HELMSDALE DR CARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TA	PROVIDER'S PLAN OF CORRECT G (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIATION	OULD BE	(XS) COMPLETION DATE

Continued From page 11 confirmed clients #2, #3 and #4 had not received their visuals examinations. W 214 INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 3 audit clients (#3) had a psychological assessment completed within 30 days of admission. The finding is: Review on 5/15/23 of client #3's record revealed he was admitted to the facility on 1/18/23. Further review indicated client #3's psychological assessment was completed by another agency on 5/22/0. During an interview on 5/16/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 did not have current/updated psychological assessments that were completed or within 30 days of admission. Further interview revealed the QIDP is the person who is responsible to ensure psychological assessments are completed for newly admitted clients. W 221 INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an auditory examination for 3 of 3 audit clients (#2, #3 and #4). The findings are: Please see page 14 of 19.	W/210		****		
During an interview on 5/16/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 did not have current/updated psychological assessments that were completed within 30 days of admission. Further interview revealed the QIDP is the person who is responsible to ensure psychological assessments are completed for newly admitted clients. W 221 INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an auditory examination for 3 of 3 audit clients (#2, #3 and #4). The findings are: Please see page 14 of 19.	W 210	confirmed clients #2, #3 and #4 had not received their visuals examinations. INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 3 audit clients (#3) had a psychological assessment completed within 30 days of admission. The finding is: Review on 5/15/23 of client #3's record revealed he was admitted to the facility on 1/18/23. Further review indicated client #3's psychological assessment		Please see page 12 of 19. Deficiency W214 will be corrected by completing the following: A. Team will ensure that a comprehensive function assessment is completed (specific to psychological needs) will be completed within 30 days of admission. B. Team will ensure consultation with Psychologist upon admission to the group home. C. Team will ensure that all psychological data and documentation is current and applicable to residents needs. D. QIDP to complete behavioral notes monthly and consult with psychologist as needed to address ongoing needs of the resident. E. QIDP to monitor monthly. F. Area Supervisor and/or Site Supervisor to inservice staff as changes in psychological	
STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CLIA		During an interview on 5/16/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 did not have current/updated psychological assessments that were completed within 30 days of admission. Further interview revealed the QIDP is the person who is responsible to ensure psychological assessments are completed for newly admitted clients. INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an auditory examination for 3 of 3 audit clients (#2, #3 and #4). The findings are:	W 221	G. Area Supervisor and/or Site Supervisor to monitor monthly. Please see page 14 of 19.	

PLAN OF CORR	F DEFICIENCIES AND LECTION	(XI) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:				E SURVEY PLETED	
		34G253	B. WING				05/16/2023
	LE GROUP HOME			13	TREET ADDRESS, CITY, STAT 317 HELMSDALE DR ARY, NC 27511	FE, ZIP COI	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	TAG	PROVIDER'S PLAN CORRECTION (EACH CORRECTIVE A SHOULD BE CROSS-REFERENCED TO APPROPRIATE DEFICIE	CTION O THE	(X5) COMPLETION DATE

W 221		W 221	Deficiency W221 will be corrected by	7/15/2023
	Continued From page 12	000 00 000 00	completing the following:	
			A. Team will ensure	
	A. Review on 5/15/23 of client #2's record		assessments and	
	A. Review on 5/15/23 of client #2's record revealed he had not received an auditory examination.		examinations specific to	
	Further review revealed client #2 was admitted to the		audio will be completed	
			within 30 days of	
	facility on 3/6/23.		admission.	
	B. Review on 5/15/23 of client #3's record		B. RN will consult with the	
			team when outdated appointments are noted.	
	revealed he had not received an auditory examination.		C. Team will address	
	Further review revealed client #3 was admitted to the		pertinent appointments	
	facility on 1/18/23.	,	during CORE team	
	C. Review on 5/15/23 of client #4's record		meetings.	
			D. QIDP to monitor monthly.	
	revealed he had not received an auditory examination. Further review revealed client #3 was admitted to the		E. RN to monitor monthly.	
			F. Area Supervisor and/or Site Supervisor to monitor	
	facility on 2/28/23.		monthly.	
	D 1 - 1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-			
	During an interview on 5/16/23, the Qualified			
	Intellectual Disabilities Professional (QIDP)			
	confirmed clients #2, #3 and #4 had not received their			
	auditory examinations.			
W 249		W 249		
	CFR(s): 483.440(d)(1)			
	As soon as the interdisciplinary team has formulated a			
	client's individual program plan, each client must			
	receive a continuous active treatment program			
	consisting of needed interventions and services in			
	sufficient number and frequency to support the			
	achievement of the objectives identified in the			
	individual program plan.			
	This STANDARD is not met as evidenced by: Based			
	on observations, record reviews and interviews, the			
	facility failed to ensure 2 of 3 audit clients (#2 and #3)			
	received a continuous active			
		,	Please see page 15 of 19.	
			riease see page 13 01 19.	

	AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			16/2023		
	OVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP C 1317 HELMSDALE DR CARY, NC 27511	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE APPR	ON SHOULD BE	COMPLETION DATE

W 249		W 249		W249 will be corrected by completing the	7/15/2023
	Continued From page 13 treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) around adaptive dining equipment. The findings are: A. During dinner observations in the home on 5/15/23, client #2 was observed eating his dinner from a regular plate. Client #2 was observed using a regular fork with a red built up handle. At no time was client #2 prompted to use a high sided divided plate or a small angled built up handle spoon. Additional observations revealed client #2 using his fingers three times to pick up his food, which landed on the table while he was scooping his food. Review on 5/15/23 of client #2's IPP dated 4/14/23 stated he uses a small angled built up handle spoon and high sided divided plate for all his meals. Review on 5/16/23 of client #2's Occupational Therapy (OT) evaluation dated 3/29/23 stated, "Therapist tried a small built up handle angled spoon and pt. was able to use it on his own during observation conducted on 03/29.2023. Therapist is recommending use of a small bowled good grip bendable spoon to prevent spoon overloading and also to provide a comfortable and stable grasp on utensil handle. Therapist left one spoon for pt. to try during visit on 03/29/2023." Further review revealed. "Pt. has difficulty scooping from a regular plate and will benefit from using a High sided divided plate". During an interview on 5/16/23, the Home Manger (HM) stated there was a built up handle spoon for client #2, but it could not be located in the home.		H. 7	Team will ensure proper use of adaptive equipment for each resident in the home. Team will consult with contract workers (OT, PT, Nutrition, and SLP to ensure appropriate use of adaptive equipment. Management will ensure that all staff are trained on resident's use of adaptive equipment. Area and/or Site Supervisor to ensure operable adaptive equipment is in the home and ready for use when needed. QIDP to monitor monthly. Area Supervisor and/or Site Supervisor to monitor monthly.	
				Laray B. (B	TO ALCOHOLD

STATEMENT O PLAN OF CORE	F DEFICIENCIES AND RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	IPLE CONSTRUCTION NG	COMP	LETED
		34G253	B. WING_	AAA MAAA MAAA	05/	16/2023
	OVIDER OR SUPPLIER ALE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP COD 1317 HELMSDALE DR CARY, NC 27511	ÞE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX T	PROVIDER'S PLAN OF COR AG (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE APPROP	SHOULD BE	(X5) COMPLETION DATE

W 249			W 249	Please see page 15 of 19.	7/15/2023
	Continued From page	e 14			
	Intellectual Disabiliti	on 5/16/23, the Qualified es Professional (QIDP) stated sided divided plate in the home			
	5/15/23, client #3 wa a regular plate. At no use a high sided divided revealed client #3 eat	servations in the home on s observed eating his dinner from time was client #3 prompted to ded plate. Further observations ting food from off the table that was scooping his food.			
	date) stated "Pt. has or plate and will benefit	f client #3's OT evaluation (no lifficulty scooping from a regular from using a High sided divided a high sided divided plate for pt. es can be ordered".			
	- the state of the	on 5/16/23, the QIDP stated there divided plate in the home for			
W 263		ORING & CHANGE ()(ii)	W 263		
	conducted only with the client, parents (if guardian.	d ensure that these programs are the written informed consent of the client is a minor) or legal not met as evidenced by: Based			
	on record review and	interview, the facility failed to			
	the written informed	grams were only conducted with consent of a legal guardian. This clients (#2, #3 and #4). The			
				Please see page 17 of 19.	
STATEMENT PLAN OF COI	OF DEFICIENCIES AND RRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G253	Andrew Control March 1999		05/16/2022
NAME OF P	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	05/16/2023
HELMSD	ALE GROUP HOME			317 HELMSDALE DR CARY, NC 27511	
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPRIATE DI	O BE COMPLETION

REGULATORY OR LSC IDENTIFYING INFORMATION)

TAG

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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

OMB NO. 0938-0391

W 263		W 263		7263 will be corrected by completing the	7/15/2023
			following:		
	Continued From page 15			eam will ensure that all restrictive	
	During observations in the home on 3/6/23, the			terventions and practices are noted within the sident's ISP's and BSP/BSG's and consented	
	surveyor noticed that the door leading into the garage was locked. Upon further observations it was noticed			oon by legally responsible parties (LRP's).	
	that a refrigerator containing food and other food		B. Te	eam will ensure data collection of behaviors	
	items on shelves were being kept in the garage.			lated to food stealing. rea supervisor will ensure healthy and safe	
	Further observations revealed staff had to use a key to unlock the door.		foo the	od options are kept in the main refrigerator in the home and excess food is kept in the	
	A. Review on 5/15/23 of client #2's Individual			frigerator in the garage. IDP to complete behavioral notes monthly	
	A. Review on 5/15/23 of client #2's Individual Program Plan (IPP) dated 4/14/23 did not include a			nd consult with psychologist as needed to	
	signed consent allowing the door where the food was			ddress ongoing needs of the residents. IDP to monitor monthly.	
	kept to be locked.			rea Supervisor and/or Site Supervisor to in-	
				ervice staff and monitor monthly.	
	B. Review on 5/15/23 of client #3's IPP dated 2/10/23 did not include a signed consent allowing the				
	door where the food was kept being locked.				
	door where the root was kept being rooked.				
	C. Review on 5/15/23 of client #4's IPP dated				
	4/14/23 did not include a signed consent allowing the				
	door where the food was kept locked.	•			
	During an interview on 5/15/23, Staff A revealed the				
	door where the food is stored is locked due to the fact				
	that client #3 has diabetes and he has a behavior of				
	stealing food.				
	During an interview on 5/16/23, Staff B confirmed the				
	door to the garage where the food is stored is always				
	locked. Staff B went on to say they were never told				
	the exact reason why the door is kept locked.				
	During an interview on 5/16/23, the Qualified				
	Intellectual Disabilities Professional (QIDP)				
	confirmed the pantry is locked, due to the fact that				
	client #3 has diabetes and he steals food.				
W 351		W 351	Please see pa	age 18 of 19.	
	SERVICE				

Date Date Date Date Date Date Date Date		(XI) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SUR VEY COMPLETED	
		34G253	B. WING	···	05/	16/2023	
	OVIDER OR SUPPLIER ALE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1317 HELMSDALE DR CARY, NC 27511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAC	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIAT	OULD BE	(X5) COMPLETION DATE	

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

OMB NO. 0938-0391

Continued From page 16 CFR(s): 483.460(f)(1) Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a dental examination for 1 of 3 audit clients (#3). The finding is: Review on 5/15/23 of client #3's record revealed he has not received a dental examination. Further review client #3 was admitted to the facility on 1/18/23. During an interview on 5/15/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 has not received an dental examination. Further interview revealed client #3's father normally accompanies client #3 to his medical appointments; but has been unable to do so lately. W 382 W 382 DRUG STORAGE AND RECORDKEEPING Deficiency W351 will be corrected by completing the following: A. Team will ensure that all appointments are completed as recommended by the facility and/or physician. B. Team will ensure that dental appointments are completed within 30 days of admission. C. R. Nill consult with team concerning medical appointments and provide assistance when needed. D. QIDP to address medical appointments during CORE team meetings. E. QIDP to monitor monthly. F. RN to monitor twice a month. G. Area Supervisor and/or Site Supervisor to monitor twice monthly.	W 351		W 351		7/15/2023
This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a dental examination for 1 of 3 audit clients (#3). The finding is: Review on 5/15/23 of client #3's record revealed he has not received a dental examination. Further review client #3 was admitted to the facility on 1/18/23. During an interview on 5/15/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 has not received an dental examination. Further interview revealed client #3's father normally accompanies client #3 to his medical appointments; but has been unable to do so lately. W 382 DRUG STORAGE AND RECORDKEEPING A. Team will ensure that all appointments are completed as recommended by the facility and/or physician. B. Team will ensure that all appointments are completed within 30 days of admission. C. RN will consult with team concerning medical appointments and provide assistance when needed. D. QIDP to address medical appointments during CORE team meetings. E. QIDP to monitor twice a month. G. Area Supervisor and/or Site Supervisor to monitor twice monthly. W 382		Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was			
The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to ensure	W 382	on record review and interviews, the facility failed to ensure a dental examination for 1 of 3 audit clients (#3). The finding is: Review on 5/15/23 of client #3's record revealed he has not received a dental examination. Further review client #3 was admitted to the facility on 1/18/23. During an interview on 5/15/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 has not received an dental examination. Further interview revealed client #3's father normally accompanies client #3 to his medical appointments; but has been unable to do so lately. DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(1)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, document review and	W 382	following: A. Team will ensure that all appointments are completed as recommended by the facility and/or physician. B. Team will ensure that dental appointments are completed within 30 days of admission. C. RN will consult with team concerning medical appointments and provide assistance when needed. D. QIDP to address medical appointments during CORE team meetings. E. QIDP to monitor monthly. F. RN to monitor twice a month. G. Area Supervisor and/or Site Supervisor to monitor twice monthly.	
For tag W382 please see page 19 of 19.				For tag W382 please see page 19 of 19.	

STATEMENT OF PLAN OF CORE	F DEFICIENCIES AND RECTION	(XI) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:	A. BUILDII	A. BUILDING		(X3) DATE SURVEY COMPLETED	
	34G253		B. WING_	B. WING		05/16/2023	
	OVIDER OR SUPPLIER ALE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP COI 1317 HELMSDALE DR CARY, NC 27511	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TA	PROVIDER'S PLAN OF COR AG (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE APPROP	SHOULD BE	(X5) COMPLETION DATE	

W 382 Continued From page 17 medications remained locked except when being prepared for administration. The finding is: During observations in the home on 5/15/23, the surveyor opened the refrigerator and noticed a black box inside. The surveyor asked Staff A to remove the box from the refrigerator. Pather observations revealed it was unlocked and client #3's insulin was being kept inside. Review on 5/15/23 of client #3's Individual Program Plan (IPP) revealed he was admitted to the facility on 1/18/23. During an interview on 5/15/23, Staff A reported client #3's insulin needs to be refrigerator. During an interview in 5/15/23, the Home Manager (HM) stated he would go get a box with a lock to store client #3's insulin in the refrigerator. During an interview and 5/15/23, the Qualified Intellectual Disabilities Professional (QIDP) revealed he was unaware that client #3's insulin was being stored in the refrigerator.				OMB NO. 0938-0391
	W 382	medications remained locked except when being prepared for administration. The finding is: During observations in the home on 5/15/23, the surveyor opened the refrigerator and noticed a black box inside. The surveyor asked Staff A to remove the box from the refrigerator. Further observations revealed it was unlocked and client #3's insulin was being kept inside. Review on 5/15/23 of client #3's Individual Program Plan (IPP) revealed he was admitted to the facility on 1/18/23. During an interview on 5/15/23, Staff A reported client #3's insulin needs to be refrigerated; that is way is is kept in the refrigerator. During an interview in 5/15/23, the Home Manager (HM) stated he would go get a box with a lock to store client #3's insulin in the refrigerator. During an interview on 5/15/23, the Qualified Intellectual Disabilities Professional (QIDP) revealed he was unaware that client #3's insulin was being	W 382	following: A. Team will ensure proper storage of medications in the home. B. Team will ensure that insulin in kept refrigerated in a locked box. C. QP, RN, AS and/or SS to monitor the fridge when monitoring the medication closet monthly. D. RN and the Site Supervisor to in-service staff on how insulin is to be stored and locked. E. QIDP to monitor monthly. F. RN to monitor twice monthly. G. Area Supervisor and/or Site Supervisor to