STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	**1317 HELMSDALE DR CARY, NC 27511**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on 7/31/25 for Intakes #NC00232658 and #NC00232707. The complaints were substantiated. Deficiencies were cited. It was determined by the team on site that an immediate jeopardy was present to the clients. The interdisciplinary team was able to develop a comprehensive plan to remove the jeopardy to the clients, which was accepted by the survey team before exiting the facility.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to implement written policies and procedures that prohibited neglect of clients (W149).	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility neglected to ensure its policies and procedures that prohibit physical abuse and neglect were implemented to protect 6 of 6 clients in the home (#1, #2, #3, #4, #5, and #6). The findings are: A. The facility neglected client #1 by failing to adequately monitor and maintain supervision regarding repeated elopements from the home.	W 149		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 149	Continued From page 1 Review on 7/31/25 of the Incident Response Improvement System (IRIS) report, dated 7/14/25, revealed on 7/12/25 at 7:30am, the facility Program Director (PD) was contacted by the on-call area supervisor and informed that a Helmsdale client had eloped from the home and was back at the group home following the contact of the police. The time of client #1's elopement cannot be determined. The area supervisor inquired about the individual being evaluated by medical professionals. The home supervisor informed the PD that staff reported that client #1 eloped through the fence in the back yard, which had been recently damaged during a storm. "The police were called by staff, and emergency medical services evaluated client #1". At 10:30am, the police officer notified the home manager to state that he was making his rounds in the area and spotted client #1 walking down the street, unclothed. When the officer arrived at the home with client #1 and inquired if the individual was missing, staff reported they did not have a client missing. Once the officer provided a description of client #1, the staff then identified him. He returned home with no further incident. Both third shift staff members were placed on administrative leave and an investigation was immediately started. Child Protective Services (CPS) came to the home to complete a safety assessment, and the guardian was notified. Following the investigation, both third shift staff members were terminated. Further review of the IRIS report revealed client #1 eloped from the group home a second time on 7/13/25 "around 6:30am". He went to the local gas station and stole a bag of Skittles and a Sprite. He was picked up by the police and returned to the group home without incident or	W 149		

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	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

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W 149	Continued From page 2 harm. Additional review of the IRIS report revealed incident prevention includes: *Staff should follow the behavior support plan (BSP) as written and follow cues when he is about to elope. *Desire for food is another indicator he may run. *Staff are to ensure door chimes/alarms are in use at all times. *If alarms are inoperable, they should report immediately. *Maintenance will ensure the fence is repaired to ensure the individuals cannot jump the fence. *Staff should keep the individual in visual line of sight at all times. *Staff should provide proper supervision to members by remaining awake while on shift. *Staff should report incidents to management immediately. Review on 7/31/25 of the facility investigation, dated 7/12/25 - 7/15/25, revealed client #1 had eloped from the home on the morning of 7/12/25. Although staff stated they had seen client #1 in his room at 5:30am, the time of his elopement could not be determined. The investigation included staff and resident interviews, review of BSPs, nursing notes, and behavior data. A report was submitted to the Incident Response Improvement System (IRIS). The findings of the investigation revealed client #1 has a target behavior of elopement. On 7/12/25, he exited the home through the back hallway door and broken fence, naked, and made his way to a busy intersection. He was returned to the home by police officers at 7:30am. Further review of the investigation revealed a	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

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W 149	Continued From page 3 work order was submitted on 7/12/25 for alarms to be checked and the fence to be repaired. Staff were instructed to "remain vigilant in watching clients" until the fence could be repaired. There were no reports of the alarms not working prior to 7/12/25. Client #1 was placed on 1:1 supervision during waking hours. On 7/13/25, maintenance found that the alarm batteries had been removed from one alarm and two alarms were turned facing the ceiling, resulting in them not functioning properly. Additional review of the investigation revealed the facility substantiated neglect due to client #1 leaving the home without knowledge and staff failing to monitor. Recommendations for prevention included retraining all staff on sleeping on duty policies, behavior support plans (BSPs), autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and active treatment. In addition, the following recommendations were made: *Ensure preferred snacks are in the home for members (Sprite and Skittles). *Behaviorist will be consulted to address behaviors. *The possibility of cameras in the home will be explored with the human rights committee. *Team monitoring will be increased on the weekends, *A weekly report will be submitted. *Maintenance, Site Supervisor, and the Area Supervisor will ensure alarms are functioning. *Staff involved in the incident will be terminated. Review on 7/31/25 of facility incident reports, dated 6/1/25 - 7/31/25, revealed on 7/12/25 the PD was contacted by the home supervisor stating that client #1 had eloped from the home. The	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 4	W 149		

incident was noted to occur at 7:00am. The police were called, and he was back at the home. At 7:40am, staff on duty reported client #1 had eloped through a hole in the home fence. Per the staff, they followed client #1 but "could not keep up with him". Emergency medical services were called to the home to evaluate client #1. At 10:17am, the police department notified the home supervisor that client #1 was found unclothed a mile from the home. When the police officer arrived at the home and asked if a client was missing, the staff replied, "No". When the police officer gave a description of client #1, "the staff stated it was probably their client". The time which client #1 left the home could not be determined. The Program Director placed both staff on administrative leave, and an investigation was requested on the same day. Child Protective Services (CPS) assessed the home and interviewed all clients, as well as guardians, on the same day.

Review of police reports, dated 7/12/25 - 7/13/25, revealed client #1 was reported as missing on 7/13/25 at 5:44am. Staff stated they thought he left the home at approximately 5:40am, and the alarm did not go off because it was not working. In addition, a hole was in the fence due to the recent storm. At 6:14am, client #1 was located at a nearby station, eating candy and drinking soda. He was wearing only a shirt, with no pants, underwear, shoes, or socks. He was transported to the home by police officers, who noted that feces was left in the seat of the vehicle, causing concern with cleanliness in the home. After returning to the home, the officers reviewed traffic camera footage to discover client #1 walking down the middle of the road without looking for vehicles that were coming and completely

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	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

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W 149	Continued From page 5	W 149		

disregarding traffic signals. CPS was contacted regarding the incident.

Review on 7/31/25 of client #1's individual program plan (IPP), dated 6/11/25, revealed he is a 16-year-old with a diagnosis of moderate intellectual disability, ASD, ADHD, Epilepsy, Speech Disorder, and Hearing Loss. He attempts to elope from the home at random moments. The staff say they "are able to stop him the majority of the time before getting too far". However, there have been a few instances where the police were contacted due to him getting out of sight.

Review on 7/31/25 of client #1's BSP, dated 6/12/25, revealed he has a history of elopement, fidgeting, pacing, separation anxiety, hyperactivity, and tantrum behavior. His elopement has been an ongoing concern and has used a GPS tracker ankle device in the past. He has attempted to elope from the home two times since admission, often displaying food-seeking behavior. The facility has provided redirection, counseling, enhanced supervision, and psychiatric treatment.

Further review of the BSP revealed current behaviors of concern are elopement and food-seeking. Staff should be aware that he may elope from his setting if his environment is loud, crowded, chaotic or he is bored and not engaged in an activity. In addition, if he sees food items he wants or is anxious, he may attempt to elope. He does not possess adequate community safety skills and should never be left unattended outside. His supervision should be increased to line-of-sight supervision while in the community due to potential dangers associated with elopement. His home should be equipped with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

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W 149	Continued From page 6	W 149		

chime alarms on all exit doors and his bedroom window to alert staff if doors are opened. In addition, he will wear a GPS tracking watch that monitors his whereabouts. To deter him from wanting to leave, staff should ensure he is engaged in stimulating activities and closely supervised throughout the day. Following an incident of elopement, he should receive 15-minute checks to ensure his safety for two hours. Staff should provide client #1 with a structured, daily schedule with minimal variability as a preventative measure.

Review on 7/31/25 of client #1's behavior data, dated 6/1/25 - 7/31/25, revealed the following:
*On 6/3/25, while staff was preparing lunch, they noticed client #1 was out of sight and went outside to see if he had left the home. Staff notified management and called emergency services. After a few minutes, he was located and safely back at home.
*On 6/25/25 during the morning, client #1 engaged in multiple elopement attempts by running out of the back door without clothing on. Despite several redirection efforts by staff, the behavior continued intermittently throughout breakfast.
*On 7/12/25 at 6:20am, staff received a knock on the door by the police. The officers asked if they were missing any clients. The staff were unaware that client #1 had left the grounds. The officers reported he was running down the street, naked. Management was informed and an investigation was immediately started. Staff stated they had checked on client #1 at 5:30am and he was in his room.
*On 7/13/25 at 5:30am, eloped from the home as staff members were passing medications and making breakfast. The two staff rotated visuals of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

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W 149	Continued From page 7	W 149		

clients every 3 to 5 minutes. The door alarms never sounded, and staff were not aware there was a break in the fence as it was still dark. Staff immediately called 911 and management. The police brought client #1 home. Management was notified the alarms were not working on the back doors and the fence was broken.

Observations on 7/31/25 in the home from 7:30am - 8:15am revealed two staff on duty with six clients. Client #1 (1:1 supervision) ran from room to room at times with both staff attempting to watch him. Client #2 jumped from the seat to other areas in the home and briefly screamed. Staff attempted to verbally redirect him. Client #3 attempted to bite Staff B, who used brief blocking to prevent injury and then redirect him. He then repeatedly pulled on the surveyor's arm to engage him in a writing activity. Client #4 (visual at all times required), remained in his room and walking the hallway out of sight at times. Client # 5 remained in the den area watching television, while client #6 walked in and out of the den. Staff attended laundry, dining, and behavior duties. No structured activity was observed.

Interview on 7/31/25 with Staff A revealed client #1 had eloped through the fence at the back of the property. The back door alarm was not working at the time but is fixed now. There were two staff on third shift, but now there are three staff on all shifts. Additionally, client #1 has a GPS watch that he wears. The third staff for the night shift left early due to an emergency this morning. No clients in the home require 1:1 supervision.

Interview on 7/31/25 with Staff B revealed client #1 did elope and will run, so he should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

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W 149	Continued From page 8	W 149		

watched. However, no clients in the home require 1:1 supervision. There have been concerns about client #4 being sexually aggressive, but he is being moved. He has made sexual comments to others. Staff B checks him every 10 - 15 minutes because she feels he can be physical with others. Staff B expressed the need for clients to have sex education so they will understand. We also need more staff. At this time, we have three staff on each shift due to behavior. We asked for a 1:1 for client #1, but management told us that would not be possible. However, if one staff is cooking and the other is doing medication administration, it leaves one staff only to manage an activity and behavior if we have only three staff on duty. The third staff left early this morning, so there are only two staff here.

Interview on 7/31/25 with the home supervisor revealed client #1 did elope. Three staff were then assigned to each shift. The management is meeting today to add additional management oversight to all shifts and especially on weekends. The alarms and fence are now repaired as well.

Interview on 7/31/25 with the Director revealed client #1 had eloped on 7/12/25 and 7/13/25. During the first elopement, he removed his clothing at the fence and was located about a mile away by the police. Staff were not aware he was gone. After the first elopement on 7/12/25, the home leadership team met and immediately started an investigation, suspended the staff, put in work orders for alarm and fence maintenance, and placed client #1 on 1:1 supervision during waking hours. During the second elopement, he left his shirt and pull-ups on and went to the store for snacks. Staff did not realize he was gone. After the second elopement on 7/13/25, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 9	W 149		

alarms and fence were repaired later that day and client #1 was placed on 1:1 supervision requirement at all times. In addition, the home secured preferred snacks to keep in the home as this was found to be a motivating factor in his elopement, and he wears a GPS tracking watch. The safety committee will be meeting today to review events from June and July and determine additional safety precautions. Later in the day, the home management team will meet to review the safety precautions.

B. The facility neglected client #6 by failing to adequately supervise the client regarding pica and elopement behaviors.

Review on 7/31/25 of facility incident reports revealed on 7/13/25 at 7:00am, client #6 eloped from the home through the front door after becoming upset with staff. Staff "had eyes on him" until he went through the woods. Staff then contacted the police and on-call staff. Client #6 was found at 8:50am and returned home. He was gone from home for 1 hour and 50 minutes. The police department expressed concern about the fence and the lack of alarm use in the home. After interviewing client #6, it was learned that he had tampered with the door alarms on the previous day (7/12/25). A work order was completed to repair the fence and adjust the alarms. Maintenance completed the repairs on the same day.

Further review of facility incident reports revealed: *On 7/16/25, client #6 became upset, swallowed thumb tacks and eloped from the home. He was followed into the woods until no longer seen. The police located client #6 in the woods and took him to the hospital. Client #6 was admitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 10	W 149		

hospital.
*On 7/27/25, client #6 began to threaten to elope and law enforcement was called. Client #6 then went outside and destroyed the trampoline, then attempted to jump the fence. The police arrived, and client #6 entered the home to punch a hole in the wall. He then tore his bed frame apart. The police assisted to de-escalate the situation. Client #6 calmed down and talked to staff before falling asleep.

Review on 7/31/25 of the IRIS revealed no report submitted of the incidents.

Review on 7/31/25 of the facility investigation, dated 7/17 - 7/18, 2025, revealed client #6 was able to obtain and swallow a thumbtack. The investigation included interviews, review of records, behavior documentation, triage nursing notes, and psychiatric treatment progress review. Client #6 was admitted to the facility on 6/23/25 with a diagnosis of mild intellectual disability, ADHD, oppositional defiant disorder (ODD), and History of Trauma. A review of the Triage report dated 7/16/25 revealed at 6:59pm, Staff E called to report client #6 had swallowed four thumb tacks. Review of behavior data, dated 7/16/25, revealed staff had directed him to finish his chores. Client #6 responded by throwing his juice and pushing one of his peers. He then snatched the thumbtacks out of the wall and stuffed them I his mouth, as well as gloves and chalk. He then ran out of the door and jumped over the fence. The facility concluded the staff did not fail to properly supervise client #6.

Review of hospital discharge papers, dated 7/18/25, revealed he was brought to the hospital on 7/16/25 due to swallowing a thumbtack, tip of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 11	W 149		

glove, and chalk. He was admitted. Psychology was consulted and did not recommend further intervention. An X-ray revealed a sharp object in the lower stomach/bowel area. A gastrologist was consulted, and an endoscopy was completed on 7/17/25. The thumb tack was not removed as it was well past the stomach area. Repeat imaging on 7/28/25 revealed it had passed.

Review of police reports, dated 7/13/25, revealed client #6 was reported as missing on 7/13/25 at 7:29am. Staff was following him on foot and flagged officers down. When they responded, client #6 ran into the woods. The staff returned home, and officers circulated the area. Client #6 was located at 8:22am at a neighborhood residence. Officers then returned him to the group home.

Review on 7/31/25 of client #6's IPP, dated 7/16/25, revealed he is a 13-year-old with a diagnosis of mild intellectual disability, ADHD, ODD, PTSD, and History of Trauma. The date of his admission was 6/24/25. His initial evaluations have been completed. However, he does not have a complete BSP currently.

Review on 7/31/25 of client #6's behavior data, dated 6/1/25 - 7/31/25, revealed the following:
*On 7/13/25, client #6 showed signs of behavior towards a peer, then refused medications and began to throw things in his room. He then went to the yard and became aggressive, pushing staff and peers. He "took off down the street" with staff following him until he went into the woods. The staff flagged down police officers who took over the search. Staff returned to the facility.
*On 7/16/25, client #6 was directed by staff multiple times to stop playing in the kitchen and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 12	W 149		

finish chores. He responded by throwing juice on the dining table and pushing down a peer. He was then redirected verbally by staff. He then responded by snatching thumb tacks out of the wall and swallowing them, as well as stuffing gloves and chalk in his mouth. He then picked up knives and dropped them, ran out of the back door and jumped over the fence. Staff ran after him and lost sight of him after he jumped over a second fence. Staff called the police and facility supervisor. The police located client #6 and transported him to the hospital.
*On 7/21/25, client #6 was in a physical fight with client #4, who had stolen an item from him.
*On 7/27/25, client #6 snatched a peer's tablet away. When staff verbally redirected him, he began to display elopement and destructive behaviors. He threatened to run away. At this point, the police were called. Client #6 then went outside and began to destroy the trampoline, then attempted to hop the fence. When the police arrived, he went inside, punched a hole in the wall, and went to his room to tear up his bed and bed frame. The officers began to de-escalate the situation, and he calmed down. His vitals were taken and staff talked with him 1:1.

Review on 7/31/25 of police reports revealed on 7/13/25, staff were witnessed following client #6 down the street and flagged them down. Officers responded to follow client #6 as he fled into the woods and encircled the area. A neighbor in the area called the police to report that he was at their home. The police located him and returned him to the group home. CPS was then contacted due to it being the third missing person from the location and fifth call within 26 hours.

Observations on 7/31/25 in the home from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 13 7:30am - 8:15am revealed two staff on duty with six clients. Client #1 (1:1 supervision) ran from room to room at times with both staff attempting to watch him. Client #2 jumped from the seat to other areas in the home and briefly screamed. Staff attempted to verbally redirect him. Client #3 attempted to bite Staff B, who used brief blocking to prevent injury and then redirect him. He then repeatedly pulled on the surveyor's arm to engage him in a writing activity. Client #4 (visual at all times required), remained in his room and walking the hallway out of sight at times. Client #5 remained in the den area watching television, while client #6 walked in and out of the den with no structured activity. Staff A attended to dining room duties and offered client #3 a second portion of cereal in the dining area in effort to address his behavior. Staff B attended to folding clothes with client #1 walking in and out of the den. No structured activity was observed, and visual supervision of client #5, as well as 1:1 supervision of client #1, was not maintained throughout the morning. Interview on 7/31/25 with Staff A revealed client #6 had eloped through the fence at the back of the property. The back door alarm was not working at the time but is fixed now. There were two staff on third shift, but now there are three staff on all shifts. However, client #6 is still new and needs to be watched. No clients in the home require 1:1 supervision. The third staff for the night shift left early due to an emergency this morning. Interview on 7/31/25 with Staff B revealed client #6 did elope and will run. He also can become violent quickly and is newer. He ran away, and the police had to be called. She is not aware of	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 14	W 149		

any clients that are 1:1 in supervision.

Interview on 7/31/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #6 had eloped more than once and swallowed thumb tacks. He feels the home would be safer with more staffing.

Interview on 7/31/25 with the home supervisor revealed client #6 did elope and needed to be watched closely. Three staff were then assigned to each shift now, but four would be provide more safety at this time and allow for structured activities. All clients in the home would benefit from structured activities. Management is meeting today to add additional management oversight to all shifts and especially on weekends.

Interview on 7/31/25 with the Director revealed client #6 had eloped and swallowed thumb tacks. He did not have surgery. She is aware that more staff are needed to support the home safety and supervision, as well as active treatment. The safety committee will be meeting, as well as home leadership, today to determine how to provide additional staff at this time. The clinical team has determined that client #6 will be discharged from the facility on 9/21/25.

C. The facility neglected client #4 by failing to adequately supervise the client regarding sexually inappropriate behaviors.

Review on 7/31/25 of the Incident Response Improvement System (IRIS) report, dated 6/30/25, revealed on 6/17/25, client #4 was observed in the bed with client #5, partially clothed. He was redirected back to his room and no further incident took place. An investigation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 15	W 149		

was initiated, and it was substantiated that client #4 had inappropriately touched client #5 on two occasions. Client #4 denied the allegation. However, client #5 stated he had touched him on his "p" on two occasions. Client #5 was taken to the hospital for evaluation and no penetration was noted. A second scope to the investigation was included to determine if staff were aware of the initial incident.

Further review of the IRIS report revealed incident prevention includes:
*Client #4 has two ABA therapists who work in the home with him 1:1 on Monday to Friday from 8:00am to 5:00pm. Outside of these hours, he is assigned a 1:1 staff during waking hours to prevent reoccurrence.

Review on 7/31/25 of the facility investigation, dated 6/18/25, revealed client #4 had been sexually aggressive toward client #5 on two occasions. On 6/13/25 during morning routines in which client #4 and #5 were found in client #5's bed together, client #4 had no pants on. At that time, a house rule was reinforced to state no clients can enter peer's bedrooms. On 6/17/25, client #4 was found in client #5's bedroom with the door closed. Client #5's pants were down. The incident was reported and clients were told to lock their own doors after entering their bedrooms. Client #4 was instructed to not enter any peer's room. The investigation included a visual inspection at the home, interviews with all staff and clients, a review of work schedules and training, BSPs, admission documentation for client #4, and individual support plan (ISP) for client #5. In addition, medical information was reviewed. All guardians in the home were notified and Child Protective Services (CPS) conducted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 16	W 149		

an investigation as well. When interviewed, client #5 stated client #4 had touched him several times in the private area which makes him uncomfortable.

Further review of the investigation interviews revealed staff were aware of client #4's sexual advances toward client #5 for at least two weeks prior to the incident and had witnessed them holding hands and sitting closely. Staff have noticed client #4 following client #5, as well as other peers in the home, when they enter the bathroom or change clothes. Staff were aware client #4 made sexual moaning noises in front of peers and had been in client #5's bedroom at 3:00am. All staff stated they had redirected client #4 or told him it was inappropriate.

Additional review of the investigation conclusions revealed that the facility determined client #4 has touched client #5 inappropriately in a sexual manner and been sexually inappropriate around his peers. In addition, the facility found client #4 had targeted client #5 and is struggling with his sexuality. The investigation concluded that client #4 was sexually abusive towards client #5. The facility recommends retraining all staff on BSPs and inappropriate advances. Client #4 and #5 will receive talk therapy. The psychologist will be notified. The clinical team will meet to determine if discharge is warranted and inform all guardians of results.

Review on 7/31/25 of a later facility investigation, dated 6/30/25, revealed client #4's guardian contacted the facility due to concerns with the clinical team's decision to discharge within 60 days. She did not feel the facility had followed his behavior support plan (BSP), and he was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 17	W 149		

properly supervised by the home. An investigation was initiated to include interviewing all staff and residents, ensuring inservice training had been completed, and case notes, as well as medical notes, were reviewed since client #4's admission on 5/29/25. Based on interviews, it was determined that client #4 is not being asked to prompt other clients or enter their rooms. On 5/28/25, staff were trained on client #4's BSP, habits, and background information. Staff were trained to always keep client #4 within line of site, except when sleeping. Based on interviews, the Qualified Intellectual Disabilities Professional (QIDP) does not spend sufficient time providing training and feedback. As a result, the facility ensured all new staff were trained by the QIDP prior to working. All staff were retrained on client #4's BSP, supervision requirements, and a 60-day discharge will be implemented due to client #4's inappropriate sexual behavior.

Review on 7/31/25 of staff training revealed the following:
*5/28/25 All staff were trained on client #4's BSP, habits, background.
*5/15/25 All staff were trained on client #1's BSP, habits, background.
*5/28/25 All staff were trained on client #6's BSP, habits, background.
*7/8/25 All staff were trained on privacy, compromised privacy, entering rooms.

Review on 7/31/25 of facility incident reports, dated 6/1/25 - 7/31/25, revealed the PD was notified of inappropriate sexual behavior and an investigation was initiated. On 6/24/25, the PD returned from vacation and recommended a secondary scope to be added to the investigation to address reporting practices. On 6/27/25, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 18	W 149		

facility substantiated peer sexual abuse where client #4 was the aggressor and client #5 was the victim. On 6/30/25, the team issued an immediate discharge for client #4 due to health and safety concerns. As of 7/7/25, the police department determined the clients were incompetent to proceed and decided not to pursue the investigation any further.

Review on 7/31/25 of client #4's IPP, dated 6/24/25/25, revealed he is a 16-year-old with a diagnosis of mild intellectual disability, ASD, ADHD, Mood Disorder and Seizures. He receives ABA therapy daily on a 1:1 basis from 8:00am to 5:00pm every weekday. He has had "multiple complaints about sexually inappropriate behavior by both staff and residents since coming the home". No interventions or supports were located in the IPP for sexually inappropriate behavior. He was admitted on 5/29/25.

Review on 7/31/25 of client #4's ABA therapy suggested guidelines for behavior, no date given, revealed strategies to be used for aggression, yelling, inappropriate vocalizations, property destruction, elopement, noncompliance, antagonizing behavior and threats towards self. No reference to inappropriate sexual behavior could be located.

Review on 7/31/25 of client #4's preliminary BSP, dated 6/23/25, revealed an evaluation had been completed by the psychologist on 6/13/25. Client #4 was diagnosed with mild intellectual disability, ASD, ADHD, Generalized Anxiety Disorder, Mood Disorder, and Seizure Disorder. Target behaviors include inappropriate sexual behavior, intrusive behavior, property destruction, disruptive behavior, elopement, threatening behavior, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 19	W 149		

uncooperative behavior. Due to the serious nature of his intrusive and possible inappropriate sexual behaviors, he should be in sight at all times during waking hours (with privacy in his bedroom and bathroom). However, he should be accompanied to the bathroom and given privacy in the stall after ensuring he is alone. He represents a significant danger of injury to others and to himself if retaliated against.

While the formal plan is being finalized, the psychologist stated the following would be recommended:
*Enhanced supervision (line of sight during waking hours) will be implemented.
*Door chimes on his bedroom door and all exit doors of the home will be ensured.
*30-minute checks when sleeping to ensure he is asleep and not engaging in inappropriate behavior.
*A highly structured and consistent daily routine will be provided.
*Access to fidget toys at all times.

Observations on 7/31/25 in the home from 7:30am - 8:15am revealed two staff on duty with six clients. Client #4 (visual at all times required), partially remained in his room and partially walked in the hallway back and forth to the den. He was out of sight at times, as peers walked freely to their bedrooms and other parts of the home. No structured activity was observed.

Interview on 7/31/25 with Staff A revealed she is a PRN staff and is not always at the home. However, she is aware that clients do elope and that client #4 has made sexual advances.

Interview on 7/31/25 with Staff B revealed she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 20	W 149		

has heard client #4 make sexual comments to other clients but has not observed him to be physical. However, she is concerned about him touching other clients and makes a point to check on him every 10 - 15 minutes. Client #4 seems confused about sex and would benefit from education.

Interview on 7/31/25 with the home supervisor revealed client #4 was found in the bedroom with client #5 and had made sexual comments more than once. He has a 1:1 therapist during the week, but his supervision is visual at all times when awake now. Without enough staff to watch the 1:1 client, ensure active treatment goes on, and other behaviors are handled, it is more difficult. He is scheduled for a 60-day discharge.

Interview on 7/31/25 with the QIDP revealed the inappropriate behavior came as a surprise because the introductory questionnaire that was completed by the facility, as well as background documents, did not mention inappropriate sexual behavior as a target behavior. In addition, the ABA therapist and program never mentions this as an issue.

Interview on 7/31/25 with the Director revealed client #4 has been found in the bedroom with client #5, twice. He has also made sexual noises and remarks on the van in front of peers. No information on this behavior was mentioned in his incoming documents or admission interviews. The team has decided to discharge client #4 on 9/7/25 due to safety concerns. His guardian is trying to secure a home for him, and they are working on a transition plan.

Review on 7/31/25 of the facility's policy on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 21 Protection from Abuse and Neglect defined Neglect as, "failure to provide care and services necessary to maintain the mental health, physical health and well-being of the client." Further review of this policy confirmed staff should complete an incident report as soon as possible, but no later than the end of their shift. The report should include all relevant information including time of day, possible witnesses, and physical description of any possible abuse. Further review of this policy indicated failure to report incidents of abuse will result in disciplinary action. The facility neglected to ensure adequate supervision for client safety, supervision, and active treatment. Both clients #1 and #6 had eloped twice, putting them in physical danger and requiring the police department to locate them. Due to these events, client #1 was to be provided with 1:1 supervision to ensure his safety. Client #6 was not ensured of increased supervision to protect his safety. In addition, the facility substantiated that client #4 had exhibited sexually targeted, inappropriate behavior towards peers and determined that he needed visual supervision at all times when awake to ensure safety of all clients in the home. However, 1:1 supervision was not consistently provided to client #1 and visual supervision was not consistently provided to client #4 on 7/31/25 during morning observations. Although clients #1, #4, and #6's IPP's revealed they should receive a "highly structured environment" observations on 7/31/25 further revealed no structured activities for any clients in the home and a chaotic atmosphere in which the risk of another elopement or sexually inappropriate incident could have occurred.	W 149		
W 158	FACILITY STAFFING	W 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 158	Continued From page 22 CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: The facility failed to: provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans (W186). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated Facility Staffing.	W 158		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure there were sufficient staff to supervise and assist 3 of 6 audit clients (#1, #4, and #6) in behavior management, ensure safety, provide active treatment. The findings are: A. Review on 7/31/25 of client #1's individual program plan (IPP), dated 6/11/25, revealed he is a 16-year-old with a diagnosis of moderate intellectual disability, autism, attention deficit hyperactivity disorder (ADHD), Epilepsy, Speech Disorder, and Hearing Loss. He attempts to elope from the home at random moments. The staff say they "are able to stop him the majority of the time	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 186	Continued From page 23	W 186		

before getting too far". However, there have been a few instances where the police were contacted due to him getting out of sight. He was admitted to the facility on 5/12/25.

Review on 7/31/25 of client #1's behavior support plan (BSP) dated 6/12/25, revealed he has a history of elopement, fidgeting, pacing, separation anxiety, hyperactivity, and tantrum behavior. His elopement has been an ongoing concern and has used a GPS tracker ankle device in the past. He has successfully attempted to elope from the home two times since admission, often displaying food-seeking behavior. The facility has provided redirection, counseling, enhanced supervision, and psychiatric treatment.

Further review of the BSP revealed current behaviors of concern are elopement and food-seeking. Staff should be aware that he may elope from his setting if his environment is loud, crowded, chaotic or he is bored and not engaged in an activity. In addition, if he sees food items he wants or is anxious, he may attempt to elope. He does not possess adequate community safety skills and should never be left unattended outside. His supervision should be increased to line-of-sight supervision while in the community due to potential dangers associated with elopement. To deter him from wanting to leave, staff should ensure he is engaged in stimulating activities and closely supervised throughout the day. Following an incident of elopement, he should receive 15-minute checks to ensure his safety for two hours. Staff should provide client #1 with a structured, daily schedule with minimal variability as a preventative measure. Supervision while in the home could not be located in the BSP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 186	Continued From page 24 Review on 7/31/25 of client #1's behavior data, dated 6/1/25 - 7/31/25, revealed the following: *On 6/3/25, while staff was preparing lunch, they noticed client #1 was out of sight and went outside to see if he had left the home. Staff notified management and called emergency services. After a few minutes, he was located and safely back at home. *On 6/25/25 during the morning, client #1 engaged in multiple elopement attempts by running out of the back door without clothing on. Despite several redirection efforts by staff, the behavior continued intermittently throughout breakfast. *On 7/12/25 at 6:20am, staff received a knock on the door by the police. The officers asked if they were missing any clients. The staff were unaware that client #1 had left the grounds. The officers reported he was running down the street, naked. *On 7/13/25 at 5:30am, client #1 eloped from the home as the staff members were passing medications and making breakfast. The two staff members on duty rotated visuals of clients "every 3 to 5 minutes". The door alarms never sounded, and staff were not aware there was a break in the fence as it was still dark. Staff immediately called 911 and management. The police brought client #1 home. Review on 7/31/25 of the facility investigation, dated 7/15/25, revealed client #1 was provided 1:1 supervision as of 7/13/25, following his second elopement, for his safety. Interview on 7/31/25 with the Home Supervisor and Director revealed client #1 was assigned 1:1 supervision on 7/13/25 following his second elopement.	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELMSDALE GROUP HOME	1317 HELMSDALE DR CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 186	Continued From page 25 B. Review on 7/31/25 of client #6's IPP, dated 7/16/25, revealed he is a 13-year-old with a diagnosis of mild intellectual disability, ADHD, ODD, PTSD, and History of Trauma. He tends to have extreme reactions to changes in his environment and may elope or board himself in his room with furniture. His initial evaluations have been completed. However, he does not have a finalized BSP currently. He was admitted to the facilty on 6/24/25. Review on 7/31/25 of client #6's behavior data, dated 6/1/25 - 7/31/25, revealed the following: *On 7/13/25, client #6 showed signs of behavior towards a peer, then refused medications and began to throw things in his room. He then went to the yard and became aggressive, pushing staff and peers. He ran down the street with staff following him until he went into the woods. The staff flagged down police officers who took over the search. Staff returned to the facility. *On 7/16/25, client #6 snatched thumb tacks out of the wall and swallowed them, as well as stuffing gloves and chalk in his mouth. He then picked up knives and dropped them, ran out of the back door and jumped over the fence. Staff ran after him and lost sight of him after he jumped over a second fence. Staff called the police and supervisor. The police located client #6 and transported him to the hospital. *On 7/27/25, client #6 was redirected for behavior, and he began to display elopement and destructive behaviors. He threatened to run away. At this point, the police were called. Client #6 then went outside and began to destroy the trampoline, then attempted to hop the fence. When the police arrived, he went inside, punched a hole in the wall, and went to his room to tear up	W 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G253	A. BUILDING _____ B. WING _____	C 07/31/2025

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W 186	Continued From page 26	W 186		

his bed and bed frame. The officers began to de-escalate the situation, and he calmed down.

Interview on 7/31/25 with Staff B revealed client #6 is not "1:1" but staff must have eyes on him at all times because he can become violent and also elope quickly.

Interview on 7/31/25 with the Home Manager and Director revealed client #6's behaviors have been more severe than expected and he has eloped, been physically aggressive, and exhibited property destruction. Staff should keep him in eyesight for his safety.

C. Review on 7/31/25 of client #4's IPP, dated 6/24/25/25, revealed he is a 16-year-old with a diagnosis of mild intellectual disability, autism, ADHD, Mood Disorder and Seizures. He receives applied behavior analysis (ABA) therapy daily with a 1:1 therapy staff from 8:00am to 5:00pm on weekdays. He has had "multiple complaints about sexually inappropriate behavior by both staff and residents since coming the home". No interventions or supports were located in the IPP for sexually inappropriate behavior. He was admitted on 5/29/25.

Review on 7/31/25 of client #4's ABA therapy guidelines, no date given, to address his behavior revealed strategies to be used for aggression, yelling, inappropriate vocalizations, property destruction, elopement, noncompliance, antagonizing behavior and threats towards self. No reference to inappropriate sexual behavior could be located.

Review on 7/31/25 of client #4's preliminary BSP, dated 6/23/25, revealed an evaluation had been

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W 186	Continued From page 27	W 186		

completed by the psychologist on 6/13/25. Client #4 was diagnosed with mild intellectual disability, ASD, ADHD, Generalized Anxiety Disorder, Mood Disorder, and Seizure Disorder. Target behaviors include inappropriate sexual behavior, intrusive behavior, property destruction, disruptive behavior, elopement, threatening behavior, and uncooperative behavior. Due to the serious nature of his intrusive and possible inappropriate sexual behaviors, he should be in sight at all times during waking hours (with privacy in his bedroom and bathroom). However, he should be accompanied to the bathroom and given privacy in the stall after ensuring he is alone. He represents a significant danger of injury to others and to himself if retaliated against. While the formal plan is being finalized, the psychologist stated the following would be recommended client #4 receive enhanced supervision to include in line of sight at all times during waking hours and a highly structured routine.

Review on 7/31/25 the Incident Response Improvement System (IRIS) report, dated 6/30/25, revealed prevention of incidents included an ABA therapist who work in the home on weekdays from 8:00am to 5:00pm with client #4. Outside of these hours, he is assigned a 1:1 staff from the facility during waking hours to prevent reoccurrence.

Observations on 7/31/25 in the home from 7:30am - 8:15am revealed two staff on duty with six clients. Client #1 (1:1 supervision) ran from room to room at times with both staff attempting to watch him. However, 1:1 supervision could not be maintained as the two staff also completed dining duties, laundry duties, and attended to behavioral management needs of the other client

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W 186	Continued From page 28	W 186		

in the home. Client #2 jumped from the seat to other areas in the home and briefly screamed as staff tried to verbally redirect him. Client #3 attempted to bite Staff B, who used brief blocking to prevent injury. Staff A then came to take him to the dining area to offer him more cereal. Client #4 (in line of sight at all times required), either stood in his room or walked the hallway, out of sight at times. Client # 5 remained in the den area watching television, while client #6 walked throughout the home, at times out of sight. There were no structured activities and the schedule for the day was unclear. Although the two staff attempted to attend to behavioral needs, the supervision necessary for clients to remain safe and engaged in a highly structured routine were not observed.

Review on 7/31/25 of staff schedules revealed two staff scheduled for each shift in June. In addition, two staff per shift were scheduled for 7/1 - 7/20/25. On 7/21/25, the facility began to schedule additional staff to ensure three staff per shift. However, on weekends, there remained only two staff scheduled per shift. The August schedule currently displays three staff per shift for 8/1/25 - 8/4/25.

Interview on 7/31/25 with Staff A revealed she is a PRN staff and is not always at the home. However, she is concerned with having enough staff on duty to ensure safety at this time. Two staff are not adequate.

Interview on 7/31/25 with Staff B revealed she has is concerned about being able to supervise client #1, #4, and #6 while also maintaining peace in the home with other client behaviors. She does not feel it is possible with two or three staff and

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W 186	Continued From page 29	W 186		

would prefer four staff due to the high behaviors at this time. The third staff had left early this morning, leaving only two staff in the home.

Interview on 7/31/25 with the home supervisor revealed August schedule is being completed. However, without enough staff to watch the 1:1 client, ensure active treatment goes on, and other behaviors are handled, it is more difficult to keep visual contact for highest needs. The home teams are meeting to ensure more staff are available for the home today and to talk about increasing the minimum coverage in August.

Interview on 7/31/25 with the Director revealed the clinical team has decided to discharge clients #4 and #6 in September due to safety concerns and supervision requirements. Until client #4 and #6 are discharged, all home team leaders are expected to monitor this home on the weekends and provide staffing support as needed as they realize more staff are needed for safety.

The facility failed to provide enough staffing to ensure safety, supervision, and active treatment. Client #1 should receive 1:1 supervision due to repeated elopements, unclothed and in the community, putting him in danger. Staff assigned to client #1 should not supervise other clients, and should be considered 1:1 for him only. Client #6 has recently arrived at the home and has exhibited serious aggression, property destruction, and two elopements. This puts himself and others at risk with a need to be watched closely. Client #4 was found to have been sexually inappropriate in front of peers and sexually aggressive with one, targeted peer. The IRIS report stated he will be 1:1 in supervision following the incidents; his BSP revealed he

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W 186	Continued From page 30 should be in direct sight at all times. He should have been in sight at all times while awake. Client #1, #4, and #6 did not receive supervision during 7/31/25 observations to ensure both they, and their peers, were not at risk due to insufficient staffing being in the home. Likewise, there was an insufficient number of staff (2) to ensure a highly structured schedule in the home. In addition, the facility failed to schedule appropriate staff ratios in the home to adequately monitor, supervise and provide active treatment to the clients in the home. Due to the failure of the facility to maintain adequate staffing in the home, an Immediate Jeopardy was found to present due to the likelihood of client elopement, inappropriate sexual behavior, or other serious behavior which could result in the harm to clients in the home. Once identified, the facility developed a Plan of Protection to assure the safety of the clients and the Immediate Jeopardy was removed.	W 186		