STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G186	A. BUILDING _____ B. WING _____	06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLOWAY STREET HOME	4795 STANLEY ROAD DURHAM, NC 27704

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E 030	Names and Contact Information CFR(s): 483.475(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The	E 030	The unit Safety Chairperson or the designee will train all staff on the home specific Emergency Plan. The Communication Plan will include updated names and contact information for staff, patients, volunteers, patient physicians and other facilities. Training will be monitoring by the Administator and Safety Chairperson to ensure staff are trained on Emergency plan when hired and on a yearly basis as Emergency plans change In the future the Administrator will ensure the requirement for home and client specfic training for Emergency plans are met. RECEIVED JUL 13 2018 DHSR-MH Licensure Sect	8/17/18

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

Administrator 7.12.18

...ficiency 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.

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E 030	Continued From page 1 communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure an emergency preparedness (EP) communication plan was developed and maintained in compliance with Federal, State and local laws. The finding is: The facility's EP plan did not include an updated face sheet. Review on 6/19/18 of the facility's 2017 EP plan had the wrong contact information. Further review revealed the face sheet had the contact information for another group home, including the name of that group home; along with their address, phone number and the name of the previous administrator. During an interview on 6/20/18, the qualified intellectual disabilities professional (QIDP)	E 030		

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E 030	Continued From page 2 confirmed the face sheet for the facility contained the incorrect information.	E 030		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing	E 037	The unit Safety Chairperson or the designee will train all staff on the home specific Emergency Plan. The Communication Plan will include updated names and contact information for staff, patients, volunteers, patient physicians and other facilities. Training will be monitoring by the Administator and Safety Chairperson to ensure staff are trained on Emergency plan when hired and on a yearly basis as Emergency plans change In the future the Administrator/QP will ensure the requirement for home and client specfic training for Emergency plans are met.	8/17/18

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E 037	Continued From page 3 services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of	E 037		

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E 037	Continued From page 4 what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training.	E 037		

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E 037	Continued From page 5 (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure direct care staff were adequately trained on the facility's emergency prepardness (EP) plan. The finding is: Staff had not been trained on the facility's EP plan. Review on 6/19/18 of the facility's EP manual (2017) did not include any information regarding training of staff. During an interview on 6/20/18, the home manager revealed direct care staff had not been trained on the facility's EP plan. During an interview on 6/20/18, the qualified intellectual disabilities professional (QIDP) revealed direct care staff had not been trained on the facility's EP plan due to the house flooding in January 2018. Further interview revealed the QIDP forgot about the training.	E 037		

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W 249	Continued From page 6	W 249		
W 249	PROGRAM IMPLEMENTATION 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 review and staff interview, the facility failed to ensure a pattern of interactions supported the active treatment plans for 4 of 4 audit clients (#1, #3, #5, #6), specific to integrating strengths identified in the area of toothbrushing, mealtime guidelines, following prescribed diets, positioning and choicemaking. The findings are: 1. Direct care staff failed to implement client #3's toothbrushing program as written. During observations at the facility on 6/20/18 at 9am, direct care staff assisted client #3 in putting toothpaste on her toothbrush. Staff then picked up her toothbrush and brushed all surfaces of her teeth for one minute. Staff told her, " Now you are finished. Take your toothbrush in your bedroom." Client #3 did not move, so staff assisted her back to her bedroom. Review on 6/20/18 of client #3's individual program plan (IPP) dated 1/11/18 revealed toothbrushing guidelines (undated) that instructed	W 249	#1. The Habilitaion Specialist will develop formal training for client #3 and all individuals with tooth-brushing programs and ensure staff are inservice on all programs before implementing. Monitoring client individual program plan including their oral health will take place through Interaction Asssessments completed at least twice weekly for the next 30 days. In the futurem the Qualified Professional will ensure ongoing training and education will be provided to clients to maintain oral health	8/17/18

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W 249	Continued From page 7 direct care staff to assist client #3 to brush her teeth for 2.5 minutes. The steps included: use a soft brush, brush after meals and at bedtime, brush along gumline at 45 degree angle, tilt toothbrush at gumline brush against the biting surface of teeth. Interview on 6/20/18 with the habilitation specialist and qualified intellectual disabilities professional (QIDP) revealed the toothbrushing guidelines for client #3 are still current and should be followed as written. Additional interview revealed direct care staff should use a timer or a watch to ensure they are assisting client #3 with toothbrushing for 2.5 minutes. 2. Direct care staff failed to follow client #3's swallowing guidelines. During observations in the facility on 6/19/18 at 5:30pm, client #3 was served a built up plate with high sides that contained cut up chicken, dirty rice, baked beans and pieces of a blueberry biscuit. Staff sat beside her as she picked up her spoon to consume supper. She ate quickly with periodic reminders from staff to slow her pace of eating. Client #3 was served her beverages towards the end of her meal. During observations in the facility on 6/20/18 at 8:15am, client #3 was served a plate of cut up boiled egg, cut up toast, and a built up plate with cereal. When client #3 began to consume her breakfast, direct care staff gave her verbal cues form across the table to slow her pace of eating. Client #3 attempted to eat rapidly and had consumed most of her meal by 8:25am. She was offered beverages at 8:20am after she had started to consume her breakfast. Direct care	W 249	#2. The QP will inservice staff on the Dietician's recommendations and ensure they're implemented during mealtimes. Monitoring will take place through Mealtime Assessments completed at least 2 times per week for the next 30 days by the Clinical Team. In the future, the team will ensure staff are properly trained on diet changes.	

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W 249	Continued From page 8 staff sat down with client #3 at the dining room table at 8:30am. Review on 6/20/18 of client #3's swallowing guidelines (undated) developed by the facility's speech and language consultant revealed: 1) Follow diet with alternating sips of liquid with bites of food. 2) Limit portion sizes to one teaspoon, use strategies to put utensil down after each bite. 3) Pour small amounts of liquid into a cup, drink small sips. Interview on 6/20/18 with the QIDP and the habilitation specialist revealed these swallowing guidelines are current and should be followed at mealtime.	W 249		
	3. Direct care staff did not provide a variety of leisure choices for client #6. During observations on 6/19/18 at 4:35pm, direct care staff went to the leisure cabinet, took out coloring books and puzzles and gave client #6 puzzles and 2 other clients coloring books and markers. When client #6 finished the puzzle, staff stated, " We are going to play a game. Lets go get a game." Staff walked over to the leisure cabinet and took out a tabletop game. She opened up the box and started to set the table top game up on the table in the den area. She said, " I don't know how to play this game. How do you play it?" She moved several pieces around on the game board. Client #6 got up from the table and walked away to another area of the facility. Client #6 walked to the living room where another staff was working with clients #3, #5 on a coloring activity with markers. Direct care staff asked		#3. The QP will in-service all staff on active treatment in the home setting. Home Manager will ensure a schedule of activities are provided in the home which involves activities of choice for the individiuals. Monitoring will be through 2 Interactions assessments in the home per week for the next month by the clinical staff and then on a routine basis. In the future, the Interdisciplinary team will ensure active treatment is occurring in the home setting.	8/17/18

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W 249	Continued From page 9 client #6, " Do you want to color?" Client #6 walked away to the back of the facility. Review on 6/20/18 of client #6's IPP dated 5/16/18 revealed he enjoys playing cards, Connect 4, basketball and listening to music. Further review revealed client #6 does not communicate verbally but he understands what is being communicated to him. Interview on 6/20/18 with the QIDP and habilitation specialist revealed client #6 can make leisure choices. Further interview revealed he should be offered a variety of the leisure items from which to choose. 4. Client #1 was not given choice making opportunities. During dinner observations in the home on 6/19/18, staff put beans, a chicken breast and mashed potatoes with gravy on client #1's plate. At no time was client #1 asked by staff to prepare his own plate or what he wanted to eat. Additional observations revealed there was also a containter of dirty rice on the strove. Further observations revealed client #1 was standing in the kitchen area while his plate was being prepared by staff. During breakfast observations in the home on 6/20/18, staff put Frosted Flakes into client #1's bowl. At no time was client #1 asked by staff to prepare his own cereal or what type of cereal would he like to eat. Additional observations revealed there were Cheerios and Captain Crunch cereals in the pantry. During an interview on 6/19/18, staff revealed it	W 249	#4 The QP will in-service staff on the importance of providing choice during meal-time as encouraged. The food pantry will continue to be stocked to ensure all ingredients are present in the home to ensure choice are available. Monitoring will occur through 2 meal-time Assessments per week for the next month by the clinical staff and then on a routine basis. In the future, the Interdisciplinary team will ensure people are provided with choice as outline in the menu book.	8/17/18

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W 249	Continued From page 10 was part of client #1's "plan to plate his food and bring it to the table." During an interview on 6/20/18, staff revealed client #1 should have been given the opportunity to choose his own cereal to eat for breakfast. Review on 6/20/18 of client #1's IPP dated 1/10/18 revealed, "He is able to use simple words as well as make gestures to indicate what he wants." Review on 6/20/18 of client #1's communication evaluation dated 12/2017 stated, "Expressively, [Client #1] uses eye gaze, body language, physical manipulation and behaviors, as well as verbalizations, to communicate." During an interview on 6/20/18, the habilitation specialist (HS) confirmed client #1 should have been given a choices during his meals. 5. Clients #1 and #5 diet consistencies were not followed. a. During breakfast observations in the home on 6/20/18, client #1 consumed a whole boiled egg. Further observations revealed there were no staff at the table with client #1 when he consumed the boiled egg. Review on 6/20/18 of client #1's IPP dated 1/10/18 stated, "diet consistency should be quarter sized pieces....He should be monitored by staff to prevent choking; he does have a tendency of over packing his mouth with food and eating fast...." Review on 6/20/18 of client #1's choking	W 249	#5 The QP will inservice staff on the Dietician's recommendations and ensure they're implemented during mealtimes. Monitoring will take place through Mealtime Assessments completed at least 2 times per week for the next 30 days by the Clinical Team. In the future, the team will ensure staff are properly trained to prevent choking.	8/17/18

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W 249	Continued From page 11 prevention guidelines dated 1/5/18 revealed, "staff follow diet consistencies as ordered by the physician. Current diet orders are quarter size pieces...." Review on 6/20/18 of client #1's nutritional evaluation dated 12/15/17 indicated, "...cut into bite size (quarter size) pieces...." Review on 6/20/18 of client #1's physicians orders' signed 5/1/18 revealed, "Quarter size pieces...." During an interview on 6/20/18, the QIDP confirmed staff should follow client #1's diet consistency. b. During dinner observations in the home on 6/19/18, staff used a knife to cut up client #5's blueberry flavored biscuit. Review on 6/20/18 of client #5's IPP dated 5/23/18 revealed, "His current diet it...Mechanical soft...." Review on 6/20/18 of client #5's nutritional evaluation dated 4/6/18 indicated, "...All food is to be modified to a mechanical soft consistency. Review on 6/20/18 of client #5's choking prevention guidelines dated 5/18/18 revealed, "...Staff follow diet consistencies as ordered by the physician...mechanical soft...." Review on 6/20/18 of client #5's physician orders' signed 5/1/18 revealed, "...Mechanical soft...." During an interview on 6/20/18, the HS revealed all of client #5's food should be put into a food	W 249		

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W 249	Continued From page 12 processor, because his diet consistency is mechanical soft. 6. Client #1's diet was not followed. During breakfast observations in the home on 6/20/18, client #1 consumed 2 boiled eggs for breakfast. Review on 6/20/18 of client #1's IPP dated 1/10/18 stated, "...no seconds allowed." Review on 6/20/18 of client #1's nutritional evaluation dated 12/15/17 stated, "...no seconds allowed...." Review on 6/20/18 of the menu for breakfast revealed, "...1 egg any style...." During an interview on 6/20/18, the HS revealed staff should have followed client #1's diet. 4. Client #5's guidelines for his foot stool were not followed. During afternoon observations in the home on 6/19/18, client #5's foot stool was not utilized from 3:34pm until 4:22pm, while he was sitting in a chair in the living room. Further observations revealed client #5's foot stool was under the table where he was sitting. At no time was client #5 prompted to utilize his foot stool. During morning observations in the home on 6/20/18, client #5's foot stool was not utilized from 6:59am until 8:02am, while he was sitting in a chair in the living room. Further observations revealed client #5's foot stool was under the table where he was sitting. At no time was client #5	W 249	The QP will inservice staff on the Dietician's recommendations and ensure they're implemented during mealtimes. Monitoring will take place through Mealtime Assessments completed at least 2 times per week for the next 30 days by the Clinical Team. In the future, the team will ensure staff are properly trained on diet changes. The QP will inservice staff on the adaptive equipment for all Person Supported in the home. Monitoring will take place through Interactive Assessments completed in the home 2 times per week for the next 30 days. In the future, staff will be trained on active treatment and implementing the PCP as written.	8/17/18 8/17/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G186	A. BUILDING _____ B. WING _____	06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLOWAY STREET HOME	4795 STANLEY ROAD DURHAM, NC 27704

(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 249	Continued From page 13 prompted to utilize his foot stool. During an interview on 6/20/18, the home manager revealed client #5 has the foot stool to help with the edema he has in his legs. Review on 6/20/18 of client #5's IPP dated 5/23/18 revealed, "Staff should ensure his legs are elevated due to swelling in his legs...." Review on 6/20/18 of client #5's physical therapy evaluation dated 2/26/18 stated, "Recommendations:...2). Provide daily opportunities to elevated bilateral legs to assist in edema reduction...." Review on 6/20/18 of client #5's physicians orders' signed 5/1/18 stated, "Due to swelling in the lower legs, ankles, and feet both feet are to be elevated...." During an interview on 6/20/18, the HS confirmed client #5 should utilize his foot stool at all times while he is sitting at home.	W 249		