PRINTED: 12/04/2019 **FORM APPROVED** OMB NO. 0 938-03 91

		(X1) PROVIDER/SUPPLIER/CLIA	(C)MLITIRE		CONSTRUCTION		E SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BLIEDING		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	COMI	PLETED
		34G299	B WIN_		12/03/2019		
NAME OF PROVIDER OR SUPPLIER			1	S	STREET ADDRESS CITY STATE ZIP CODE		
				1	108 QUAIL-MEADOW DRIVE		
HOLLIDAY	'S PLACE GROUP HOME			F	AYETTEVILLE, NC 28314		
(VA) TD	CIIMMADV CTA	TEMENT OF DESICIENCIES	70		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			ID PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
W 125	W 125 PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)  The fac1l1ty must ensure the r1ghts of all cl1ents. Therefore the fac1l1ty must allow and encourage 1nd1v1dual cl1ents to exerc1se the1r r1ghts as cl1ents of the fac1l1ty and as c1t1zens of the Un1ted States		W 125		The facility will ensure that each client has legal representation determined by their capacity of thereof to exercise their rights.	as	1/31/20
	1nclud1ng the r1ght to to due process. Th1s STANDARD 1s Based on record rev1 fac111ty fa1led to ens	offle complaints and the right not met as evidenced by: lew and interviews the ure client #5 had the right to a ecision maker. This affected i			For Client #5, the QP will coord with the foster mother to petition clerk of court to request a hear for adjudication of incompetend and guardianship appointment	n the ring ce	
	Cl1ent #5 was not affor guard1ansh1p.				A copy of the petition and notion hearing will be maintained in the client's record.	- 3	
	9 revealed her prev1o her legal guard1an ar meet1ng. Further rev reveals a d1agnos1s	1ew of cl1ent #5's IPP			The QP will document the state the guardianship on a monthly basis.	us of	
	GERD tachycard1a a	and type II d1abetes. She			The QP will ensure that legal		1/31/20
	takes metform1n for	the d1abetes.			representation is secured and/	1	
					petition to the Clerk of Court is		
		t#5 on 12/3/1 9 at 6:55am			PARTICIPATION OF STATE OF STAT		
		ration of her medications		- 1	to obtain guardianship for all cl	ients	
		e to 1dent1fy very few of the and some of the reasons for			if needed -upon admission.		
	taking the medication						
	tak mg the medication	JIIG.			DHSR-Mental He	alth	
	Add1t1onal rev1ew o	on 12/3/1 9 of cl1ent #5's record			DH3K-Melikal ne	aitii	
		other has given consent for			000 4 0 0040		
		1nformat1on etc. Further			DEC 1 3 2019		
		record revealed that no					
	guard1ansh1p paper	work could be located.			Lic. & Cert. Sect	ion	
	Interv1ew on 12/3/1 9	w1th the fac1l1t1es ICF d1rector					
ABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asteriok (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined

at other safeguards prov1de suff1c1ent protect1on to the pat1ents. (See 1nstruct1ons,/Except for nurs1ng homes the f1nd1ngs stated above are d1sclosable 90 's 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 following the date these documents are made available to the facility. If deficiencies are cited an approved plan of correction is requisite to continued m part1c1pat1on.

		(X1) PROVIDER/SUPPLIER/CLIA	3FILLIMES)		CONSTRUCTION		TE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUIDNE		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	СОМ	PLETED
34G299		B WIN_		12/03/2019			
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS CITY STATE ZIP CODE			
HOLLIDAY	'S PLACE GROUP HOME			1	108 QUAIL-MEADOW DRIVE		
				F	AYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 125	Cont1nued From prevealed that she had the guard1ansh1p particular fac1l1t1es off1ce to of that the paperwork or power of attorney for linterv1ew on 12/3/1 9 d1sab1l1t1es profess cl1ent #5 does not har power of attorney. The cl1ent #5 would benef STAFF TRAINING PR CFR(s): 483.430(e) The fac1l1ty must profin1t1al and cont1nu1 employee to perform eff1c1ently and composite fac1l1ty were suff1c1ently tra1n the find1ng 1s:  The med1cat1on techneffect1vely tra1ned to perform the fac1l1ty tra1ned to perform the find1ng 1s:	recently requested cop1es of perwork. After call1ng the bta1n cop1es 1t was revealed in file for cl1ent #5 was for a f1nances.  with the qualified 1ntellectual 1onal (QIDP) revealed that we a legal guard1an but a e QIDP stated that he felt that fit from a legal guard1an. OGRAM (1)  wide each employee with ing tra1n1ng that enables the his or her dut1es effectively betently.  ot met as evidenced by: so record review and y fa1led to ensure all staffined to perform the1r dut1es.	W 125			ff ate R, ed the will I staff the ct	1/31/20
	In the home on 12/3/1 ass1sted three clients the 1r medications. Af pills onto a napkin the medications and 1mr	med1ately s1gned the trat1on Record (MAR) for each ents 1ngested the1r		ŀ	nome twice monthly to ensure continued compliance.	ruic	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(COMMITTRE	CONSTRUCTION		E SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	СОМІ	PLETED
	34G299		B WIN_	12/03/2019		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS CITY STATE ZIP CODE		
HOLLIDAY'S PLACE GROUP HOME			1108 QUAIL-MEADOW DRIVE			
HOLLIDAT	S PLACE GROUP HOME			FAYETTEVILLE, NC 28314		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
W 18 9	not s1gn off on the M	w w1th the MT revealed they do IAR at the t1me med1cat1ons	W 189	For all clients, the facility will e the implementation of individual program plan (IPP) intervention promote participation in meal	al	1/31/20
	go1ng to take 1t."	use "you don't know 1f they are		preparation tasks.		
	Rev1ew sheet (dated	of the MT's Med1cat1on Pass 1/30/17) revealed or g1v1ng meds - 1n1t1als"				
	med1cat1on techn1c	w1th the D1rector conf1rmed 1ans have been tra1ned to are 1ngested before s1gn1ng				
W 24 9	PROGRAM IMPLEM CFR(s): 483.440(d)(		W 249	For clients' #3 and #5 the Habilitation Specialist will provi service training to all staff on the	de in-	1/31/20
	formulated a ci1ent's each ci1ent must reconstruct treatment program co1ntervent1ons and senumber and frequence	erv1ces 1n suff1c1ent by to support the bbJect1ves 1dent1f1ed 1n the		to address client involvement in meal preparation tasks. Staff we instructed to direct these clients participate in meal preparation and the implementation of mean preparation goal training for breakfast, lunch and dinner me	rill be s to tasks	
	Based on observat1o rev1ews the fac1l1ty rece1ved a cont1nuor cons1st1ng of needer as 1dent1f1ed 1n the (IPP) 1n the area of pr	not met as ev1denced by: ns-1nterv1ews and record fa1led to ensure cl1ents us act1ve treatment program d 1ntervent1ons and serv1ces Ind1v1dual Program Plan rogram 1mplementat1on. Th1s cl1ents (#3-#5). The f1nd1ngs		Participation in meal preparation be promoted to some degree for clients in the home per their IPI.  The program manager and/or (will provide weekly observation meals in the home to ensure continued compliance.	or all Ps.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUIDNE		(X3) DATE SURVEY COMPLETED
		34G299	B WIN	12/03/2019	
NAME OF PROVIDER OR SUPPLIER HOLLIDAY'S PLACE GROUP HOME			STREET ADDRESS CITY STATE ZIP CODE 1108 QUAIL-MEADOW DRIVE FAYETTEVILLE, NC 28314	And the second s	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD I  CROSS-REFERENCED TO THE APPROPRI  DEFICIENCY)	BE COMPLETION
W 24 9	During observation 6:22am all five citer area watching telev was a pot of eggs be microwave was bee until 7:01am. At 6:33 what was for breakfaknow [Staff A] cooke surprise."  Further observations the kitchen making is Staff A was silcing be mayo and spreading sandwiches. She was sandwiches in Zipk prompted or encourathe sandwiches.  Review on 12/2/19 or revealed the need to preparation. The objective to prepare independent responsiments. Additional behavior inventory (that citent #5 is partithe areas of meal preparation. The objective to prepare independent responsiments. Additional behavior inventory (that citent #5 is partithe areas of meal preparation. The objective to prepare independent responsiments. Additional behavior inventory (that citent #5 is partithe areas of meal preparation) was also in assist with preparing 100% verbal prompts	re not afforded the twith meal preparation.  In the home on 12/3/1 9 at this were seated in the living islow. In the kitchen there onling on the stove and the eping "end." This continued is am client #1 asked Staff D ast. Staff D stated "I don't ed the breakfast. It's a staff is at 7:16am revealed Staff A in lunches for clients #3 and #5. solled eggs mixing with on bread to make sithen observed to place the oc bags. The clients were not ge to participate in making if client #5's IPP dated 4/12/1 9 improve her meal at a priority need to increase the IPP also included an a side dish with 100% sees for 10 consecutive review of client #5's adaptive ABI) dated 4/10/1 9 revealed tally to totally independent in	W 24	9	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(CZMLETIRE A BLIDNE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
34G299		B WIN_	12/03/2019		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE		
HOLLIDAY	'S PLACE GROUP HOME			1108 QUAIL-MEADOW DRIVE FAYETTEVILLE, NC 28314	
(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 CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	BE COMPLETION
W 24 9	Cont1nued From p	page 4	W 249		
	rev1ew of the cl1ent's requ1res part1al ass1 comb1nat1on d1she	s ABI dated 6/3/1 9 noted she	W 243		
	some of the cl1ents meal preparat1on. We with cooking break When asked who "ther." However, after previously stated at breakfast and it bei "Oh." Further interv	9 w1th Staff A revealed that could have ass1sted w1th when asked who ass1sted fast Staff A stated "they d1d." ney" were Staff A stated, "ask repeating what was bout Staff A cooking the ng a surprise Staff A stated lew w1th Staff A revealed could have been helping			
W 436	d1sab1l1t1es profess1	PMENT	W 436		
	repa1r and teach cl1e 1nformed cho1ces ab eyeglasses hearing a a1ds braces and othe	n1sh ma1nta1n 1n good ints to use and to make rout the use of dentures and other commun1cat1ons or dev1ces 1dent1f1ed by the arm as needed by the cl1ent.			
	Based on observat1or	not met as ev1denced by: ns 1nterv1ews and record fa1led to ensure 1 of 3 aud1t tht to use ass1st1ve dev1ces			

Rev1ew of cl1ent #5's 1nd1v1dual program plan (IPP) dated 4/12/1 9 revealed that cl1ent #5 has 1mpa1red v1s1on and requ1res glasses.

Interv1ew on 12/3/1 9 w1th the ICF d1rector revealed that cl1ent #5 does wear glasses but she breaks them. The ICF d1rector stated that staff had 1nformed her that cl1ent #5 had broken the glasses 1n half on 12/2/1 9 and then broke the leg off the glasses on 12/3/1 9. The ICF d1rector revealed that th1s 1s the th1rd t1me cl1ent #5 had broken her glasses and she does th1s on purpose because she does not want to wear them. The ICF d1rector conf1rmed that cl1ent #5 has not

eyeglasses.

		(X1) PROVIDER/SUPPLIER/CLIA	(COMLETTE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	COMPLETED	
34G299		B WIN_	12/03/2019			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE			
HOLLTDAY	'S PLACE GROUP HOME			1108 QUAIL-MEADOW DRIVE		
HOLLIDAI	3 PLACE GROUP HOME			FAYETTEVILLE, NC 28314		
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
W 436	Cont1nued From pa	age 6	W 436	j.		
	rece1ved any type of	of tra1n1ng on the				
	appropr1ateness of	f her glasses and keep1ng				
	her from break1ng	them.				
W 473	MEAL SERVICES		W 473	The facility will answer that all f	1:- 4/04/00	
	CFR(s): 483.480(b)(	2)(11)		The facility will ensure that all food is 1/31/		
				maintained at appropriate		
	Food must be serve	d at appropr1ate temperature.		temperatures and served withir	1 15	
				minutes or less to individuals.		
	This STANDARD is	not met as ev1denced by:				
		ns 1nterv1ews and record				
		1 led to ensure all foods were				
		ate temperature. Th1s		The Program Manager and	1/31/20	
		Il cl1ents res1d1ng 1n the		Habilitation Specialist will provide		
	home. The f1nd1ng 1s	5:		service training to all staff on the		
	<b>.</b>			appropriate temperatures for ho		
	Food temperatures			and cold food items. The staff w		
		s 1n the home on 12/3/1 9 at		instructed to maintain food and		
		ts were seated 1n the I1v1ng		liquids at appropriate temperatu	ıres	
		s1on. In the k1tchen there		and present the food or liquids to		
		1l1ng on the stove and the olng "end." At 6:51am the		individuals for consumption with		
		ed to the home. At 7:01am the		minutes or less. A thermometer		
		ved a bowl of gr1ts from the		be secured and used to check f		
		them to a cl1ent to put on the				
		re of the gr1ts was not		temperatures before presentation	on for	
	checked pr1or to be1	ng served.		consumption.		
	Interv1ew on 12/3/1 9	w1th the ICF d1rector				
		perature of the food should		The Program Manager and QP	Hivar	
	be checked and rehe	ated as needed. The ICF		monitor breakfast and dinner me		
		taff 1n the home have been			zais	
	tra1ned on check1ng	the temperature of foods.		in the home weekly to ensure		
				continued compliance.		



# **D&L** HealthCare Services, Inc.

1234 Hoke Loop Road, Fayetteville, NC 28314-6485

Phone: (910) 826-7648 Fax: (910) 826-7649 Email: dlhealthcare@aol.com

December 9, 2019

Ms. Wilma Worsley-Diggs, M.Ed., QIDP Facility Compliance Consultant I Mental Health Licensure and Certification Section N.C. Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

Re: Annual Recertification Survey completed December 3, 2019 Holliday's Place Group Home 1108 Quail Meadows Drive, Fayetteville, NC 28314 MHL#026-851, Provider # 34G299

Dear Ms. Worsley-Diggs:

See attached hard copy of the plan of correction (POC) for the Holliday's Place Group Home survey. We look forward to your follow-up on or after January 31, 2020. We hope that you will find the attached POC acceptable. If you have questions, please feel free to contact me directly or James Harris, QP. Otherwise, we very much look forward to your follow-up visit.

Kindest regards.

Laura Lloyd, ICF Director