

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

PRINTED: 09/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
(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	
E 037	<p>EP Training Program CFR(s): 483.475(d)(1)</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following:</p> <ul style="list-style-type: none"> (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) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the 	E 037			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 09/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
(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	
E 037	<p>Continued From page 1</p> <p>procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(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.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency</p>	E 037			

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

PRINTED: 09/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
(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	
E 037	<p>Continued From page 2 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[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 every 2 years. (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. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[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</p>	E 037			

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

PRINTED: 09/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
(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	
E 037	<p>Continued From page 3 roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[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 every 2 years.</p> <p>This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to ensure direct care staff in the home were adequately trained on the facility's emergency plan (EP). This potentially affected all the clients residing in the facility. The finding is:</p> <p>Management did not provide training to direct care staff who work in the facility.</p> <p>During an interview on 9/21/2020, Staff A stated she had not been trained concerning the facility's EP. Further interview revealed Staff A had been working in the facility for three months.</p> <p>Review on 9/21/2020 of the facility's EP revealed there was a training held on 4/16/2020 and Staff</p>	E 037			

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

PRINTED: 09/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
(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	
E 037	Continued From page 4 A's was not there. Further review revealed there were no other trainings held.	E 037			
W 249	<p>During an interview on 9/22/2020, the qualified intellectual disabilities professional (QIDP) stated Staff A will need to be trained regarding the facility's EP.</p> <p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the area of self-help skills. This affected 1 of 5 audit clients (#6). The finding is:</p> <p>Client #6 was not prompted to use his napkin at meal time.</p> <p>During lunch observations in the home on 9/21/2020 at 11:54am, client #6 wiped his mouth on his shirt sleeve. Further observations revealed client #6 had a napkin at his place setting. Additional observations revealed staff did</p>	W 249			

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

PRINTED: 09/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
(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 5 not prompt client #6 to use his napkin. During dinner observations in the home on 9/21/2020 at 5:01pm, client #6 wiped his hands on his pants. Additional observations revealed at 5:08pm, client #6 wiped his hands on his shirt. Further observations revealed client #6 had a napkin at his place setting. Additional observations revealed staff did not prompt client #6 to use his napkin. During breakfast observations in the home on 9/22/2020 at 7:34am, client #6 was observed to have food particles on the corner of his mouth when he got up from the table. Further observations revealed client #6 had a napkin at his place setting. Additional observations revealed staff did not prompt client #6 to use his napkin. Review on 9/22/2020 of client #6's comprehensive functional assessment dated 8/22/2019 revealed, "he does require some guidance/assistance with other dining tasks such as using a napkin"	W 249			
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W 369			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
(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 369	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered without error. This affected 2 of 5 clients (#4, #5) observed receiving medications. The findings are:</p> <p>Clients did not receive all medications as ordered.</p> <p>A. During observations of medication administration in the home on 9/21/2020 at 12:12pm, client #5 ingested Urocit K - 15meq and a glass of water.</p> <p>Review on 9/22/2020 of client #5's physician's orders dated 9/1 - 9/30/20 revealed an order for Urocit K - meq, take 1 tablet 4 times a day with food.</p> <p>Interview on 9/22/2020 with the facility's nurse confirmed client #5's physician's order were current and he should have taken the medication with food such as crackers.</p> <p>B. During observations of medication administration in the home on 9/21/2020 at 12:18pm, client #4 ingested Sevelamer Carb 800mg with a glass of water.</p> <p>Review on 9/22/2020 of client #4's physician's orders dated 9/1 - 9/30/20 revealed an order for Sevelamer Carb 800mg, take 1 tablet 3 times a day with food.</p> <p>Interview on 9/22/2020 with the facility's nurse confirmed client #4's physician's order were current and he should have taken the medication with food such as crackers.</p>	W 369			

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

PRINTED: 09/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
(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 388 W 388	Continued From page 7 DRUG LABELING CFR(s): 483.460(m)(1)(i) Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications were labeled appropriately. This affected 1 of 5 clients (#2) observed receiving medications. The finding is: Client #2's medication was not labeled appropriately. During observations of medication administration in the home on 9/21/2020 at 12:15pm, the medication technician administered Isopto tears sol 0.5% to client #2 which was not labeled with his name, date, physician or dosage. Interview on 9/21/2020 with the medication technician revealed that the label was faded and if she needed to look for the directions, she would have to go look at the MAR. Interview on 9/22/2020 with the facility's nurse confirmed that a new label should have been ordered and placed on the medication.	W 388 W 388			
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440			

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

PRINTED: 09/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
(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 440	Continued From page 8 This STANDARD is not met as evidenced by: Based on record review and interviews with staff, the facility failed to carry out fire drills at least monthly on each shift. This affected all the clients in the facility. The finding is: Staff failed to vary the times of the fire drills on first and second shifts. Review on 9/22/2020 of the fire drills revealed there were no fire drills on first shift for the months of July and February (2020). Further review revealed there were no fire drills on second shift for the months October, November, December (2019) and May, July and August (2020). During an interview on 9/22/2020, the qualified intellectual disabilities professional (QIDP) revealed fire drills should be done every month.	W 440			
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infections and prevent possible cross-contamination. This potentially affected all the clients residing in the home. The finding is: Universal precautions were not taken to promote client health and prevent possible	W 455			

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

PRINTED: 09/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
(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 455	Continued From page 9 cross-contamination. During breakfast observations in the home on 9/22/2020 at 7:34am, client #1 licked off the spoon he had previously used to eat his cereal, placed it in a bowl of grapes and scooped out some grapes and put them on his plate. Further observations revealed the bowl was then passed to another client, who used his clean spoon to scoop some grapes onto his plate. Additional observations revealed a third client was handed the bowl of grapes and he preceded to his spoon that he had previously used to eat his cereal. At no time were the three clients prompted not to use their personal spoons to scoop the grapes.	W 455			
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure client #4's diet guidelines were followed. This affected 1 of 5 audit clients. The finding is: Client #4's diet guidelines were not followed. During observations in the home on 9/21/2020 at 11:44am, client #4 was observed to eat a ham	W 460			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OR SUPPLIER HOLLY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HOLLY STREET GOLDSBORO, NC 27530		
(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 460	<p>Continued From page 10 and cheese sandwich with a bowl of tomato soup.</p> <p>Review on 9/21/2020 of client #4's dietary guidelines dated 6/7/2019 posted in the kitchen of the home revealed he should not consume pork or beef products, and no tomatoes or tomato based products.</p> <p>Review on 9/22/2020 of client #4's individual program plan (IPP) dated 5/21/2020 revealed client #4's diet is 1500 calorie, low sodium, low phosphorous, low potassium with limited protein.</p> <p>Review of 9/22/2020 of client #4's nutrition evaluation dated 10/7/2019 revealed client #4's diet is 1500 calorie, low sodium, low phosphorous, low potassium with limited protein and to see the list provided for full guidance for items to limit and exclude from client #4's diet.</p> <p>Interview on 9/22/2020 with Staff B revealed that client #4 is on a special diet. Staff B stated that client #4 should not have milk or milk based products unless it is soy milk, no beef or pork, and no tomatoes or tomato based products. Staff B revealed that client #4 should not have had the ham and cheese sandwich or tomato soup for lunch.</p> <p>Interview on 9/22/2020 with the qualified intellectual disabilities professional (QIDP) revealed that client #4 is on a special diet due to kidney disease and the diet guidelines posted in the home are current. The QIDP confirmed that client #4's diet was not followed as he should not have received the ham and cheese sandwich and tomato soup.</p>	W 460			