STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G178	A. BUILDING ______ B. WING ______	09/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY STREET HOME	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	EP Training Program CFR(s): 483.475(d)(1) *[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: (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. *[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 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	A review of Staff A's Personnel Record indicates that she received training regarding the EP Plan on June 22, 2020. Staff A either misspoke or misremembered the training received. Regardless, all Holly St. Home Staff will receive refresher training on the EP Plan by the Personnel Manager on or before 10-16-20. Training will be documented on the In-service Training Form. The Operations Coordinator and Program Director will review the In-service Training records to assure that all Staff have received EP Plan training.	11-21-2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jacqueline Johnson
TITLE: Program Director
(X6) DATE: 9-29-2020

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.

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

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E 037	Continued From page 1 procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[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 every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility 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 all emergency	E 037		

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E 037	Continued From page 2 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[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. *[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	E 037		

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E 037	Continued From page 3 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and 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 every 2 years. 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: Management did not provide training to direct care staff who work in the facility. 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. Review on 9/21/2020 of the facility's EP revealed there was a training held on 4/16/2020 and Staff	E 037		

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E 037	Continued From page 4 A's was not there. Further review revealed there were no other trainings held. 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.	E 037		
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, interviews and record reviews, the facility filed 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: Client #6 was not prompted to use his napkin at meal time. 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	W 249	The QP/IID and Hab Spec will review all CFAs, IPPs, and Mental Health Plans and develop a list of all specific active treatment actions and interventions for all Holly St. Consumers. The QP/IID and Hab Spec will retrain all Staff on the active treatment lists for each Consumer. The QP and Hab Spec will monitor implementation for compliance and document results on a Monitoring Form. In addition, the Program Director, Operations Coordinator and other QP Level Staff will conduct random monitoring and document results on the Monitoring Form. All actions pertinent to this deficiency will commence on October 5, 2020 and will be ongoing.	11-21-2020

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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 ...." During an interview on 9/22/2020, the qualified intellectual disabilities professional (QIDP) revealed client #6 should have been prompted to use his napkin during meal time.	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	The Plan of Correction for W249 will include specific instructions regarding Medication Administration and will follow all POC activities under W249.	11-21-2020

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W 369	Continued From page 6 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: Clients did not receive all medications as ordered. 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. 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. 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. 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. 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. 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.	W 369		

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W 388	Continued From page 7	W 388		
W 388	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	Under the direction of the Nurse Supervisor, Nursing Staff will conduct a bi-weekly audit of all medication labels to insure that each label is legible. The label that is the focus of this deficiency has already been replaced with a new legible label. As a result of the monitoring by Nursing Staff, any label that is judged to be eligible will immediately be replaced with a new label. Audits will commence the week of October 5, 2020.	11-21-2020
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		

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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	The Facility Support Coordinator will develop an annual schedule for monthly Fire Drills, that will cover both shifts and at varying times. Staff will implement drills according to the schedule and document drills on the Fire Drill Safety Check Form. Copies of the Fire Drill Safety Check Form will be maintained in the Group Home and by the Facility Support Coordinator. Any deviation from the schedule will be immediately reported to the Program Director for correction. The schedule for drills will begin October 1, 2020.	11-21-2020
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		

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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. During an interview on 9/22/2020, the qualified intellectual disabilities professional (QIDP) stated the bowl of grapes should have been removed from the table to prevent cross-contamination.	W 455	The Nurse Supervisor will conduct in-service training for all Group Home Staff regarding possible precautions to prevent cross-contamination. Training will be documented on the In-service Training Form and be completed by October 31, 2020.	11-21-2020
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		

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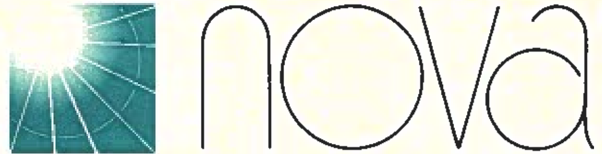
W 460	Continued From page 10 and cheese sandwich with a bowl of tomato soup. Review on 9/21/2020 of client #4's dietary guidelines dated 6/7/2019 posted in the kitchen of the home revealed he should not consume pork or beef products, and no tomatoes or tomato based products. Review on 9/22/2020 of client #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. 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. 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. 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.	W 460	The POC for W249 will include specific instructions regarding dietician guidelines for all Consumers. All POC activities for W249 will apply to this deficiency.	11-21-2020



BEHAVIORAL HEALTHCARE CORPORATION

. . . lighting the way to new beginnings

September 29, 2020

via Certified Mail: 7018 1130 0001 4262 5067

Justin Foster, MPA, QDDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section
NC Division of Health and Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Recertification Survey, completed September 21-22, 2020
Holly Street Home, 1509 Holly Street, Goldsboro, NC 27534
Provider Number 34G178
MHL# 096-114

Dear Mr. Foster:

Attached you will find the plan of correction associated with your correspondence dated September 25, 2020, along with the statement of deficiencies from the survey completed September 21-22, 2020.

Should additional information be needed, please don't hesitate to contact me.

Sincerely,

Jacqueline Johnson

Jacqueline Johnson
Program Director
ICF/IID Services
jacquelinejohnson@nova-ic.org

Attachments: Signed and dated first page of the state form
Plan of Correction: Holly Street