PRINTED: 02/04/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING 34G186 B. WING 02/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4795 STANLEY ROAD HOLLOWAY STREET HOME DURHAM, NC 27704** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) E 015 Subsistence Needs for Staff and Patients E 015 CFR(s): 483.475(b)(1) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(ii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for

hospice employees and patients, whether they evacuate or shelter in place, include, but are not

(A) Food, water, medical, and

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

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.

limited to the following:

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home.

relative to the subsistence needs of the group

Interview with staff A on 2/1/21 revealed an emergency supply of food and water was kept in the kitchen pantry of the facility. Further interview with staff A revealed the residence manager (RM) rotates this food supply every 6 months. Staff A stated this food supply has been empty since January 2021. The rotation date on the containers indicated the supply of emergency

food was to be rotated on 1/14/21.

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	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G186	8. WING		02/02/2021		
	ROVIDER OR SUPPLIER AY STREET HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 4795 STANLEY ROAD DURHAM, NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
E 015	Interview on 2/2/21 w emergency food supp since January 2021.	ith the RM confirmed the ly had not been replenished	E 015				
VV 120	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(4) The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on record review and confirmed by interviews with staff, the team failed to implement objective training to increase money management skills for 1 of 3 sampled clients (#3). The finding is:		W 128	A team meeting will be held to client #3 skills relevent to Mo Management. The Habilitation Specialist will in-service staff results of team meeting. The Qualified Professional will reverson Centered Plan with resofthe team meeting. The Client #3 Management objective through Interaction Assessments 2 times week for 1 month and then or routine basis. In the future the Qualified Professional will en Person Centered Plans included.	ney- n on vise the esults nical loney- gh mes per n a sure		
	(IPP) dated 5/6/20 reviews an agement objectiv 85% accuracy for 2 control No data could be local facility. Additional review and additional training management or budg. Interview with staff A collent #3 is not being to interview confirmed that the attending their vocation months due to the cur.	eting. on 2/1/21 this objective for rained in the facility. Further se clients have not been onal setting for over 11 rent COVID-19 Pancemic.		intervention to address client	- · · · · · · · · · · · · · · · · · · ·		
		4/2/20 revealed client #3 ance in all areas of money geting,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILDI		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G186	B. WING		02	/02/2021	
	ROVIDER OR SUPPLIER AY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4795 STANLEY ROAD DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 130	disabilities profession habilitation specialist recognize a quarter wother money manage identified for client #3 PROTECTION OF CICFR(s): 483.420(a)(7). The facility must ensurtherefore, the facility treatment and care of This STANDARD is made and the facility of 3 audit clients (#4). During observations in C took client #4 to the left him sitting on the facility took client #5 to the behim in the other bathmopen. Both bathmoom this time, female client.	ith the qualified intellectual al (QIDP) and the revealed the objective to as completed but that no ment training had been LENTS RIGHTS. Item the rights of all clients, must ensure privacy during personal needs. The facility on 2/1/21 staff bathroom at 5:35pm and soilet with the door open, rom the waist down. Staff D athroom at 5:40pm and left com toileting with the door doors were open. During t #3 walked down the meto put away an item and	W 136	3	o privacy Specialis of team ssional w Plan with Clinical S privacy ctive ek for 1 basis. In ssional Plan inclind	st (ill	
	plan (IPP) dated 3/4/2 guidelines OSG#2 for the bathroom door to toileting.	lient #5's individual program 0 revealed he has privacy staff to remind him to close safeguard his privacy during lient #5's adaptive behavior					
			1				

PRINTED: 02/04/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUIZBER: COMPLETED A. BUILDING _ 34G186 B. WING. 02/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4795 STANLEY ROAD HOLLOWAY STREET HOME DURHAM, NC 27704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID io PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY Continued From page 4 W 130 inventory (ABI) dated 2/7/20 revealed he is independent in the area of closing the bathroom door for privacy. Review on 2/2/21 of client #4's ABI dated :2/28/20 revealed he has partial independence in the area of closing the bathroom door for privacy. Interview on 2/2/21 with the qualified intellectual disabilities professional (QIDP) revealed both clients #4 and #5 require assistance from staff to ensure their privacy. Additional interview revealed both staff C and staff D have been trained on assisting clients in protecting their privacy. W 159 QIDP W 159 CFR(s): 483.430(a) A.B.C. The Administrator will in-service the Each client's active treatment program must be 4/2/21 Qualified Professional and Habilitation integrated, coordinated and monitored by a Specialist on reviewing and monitoring qualified intellectual disability professional. This STANDARD is not met as evidenced by: clients Person Supported Plans on a Based on record reviews and interviews, the monthly basis and implementing revisions qualified intellectual disabilities professional as necessary. The Qualified Professional (QIDP) failed to ensure clients' individual program. and Habilitation Specialist will be required plans (IPP's) were reviewed and revised as to submit a scheduled to the Administrator necessary. This affected 3 of 4 audit clien's (#1, which will include assessments in the #3 and #4). The findings are: home and monitoring program progress. The Administrator will monitor on a A. Review on 2/2/21 of client #1's Individual weekly basis to ensure scheduled program plan (IPP) dated 10/6/20 revealed monitoring occurs for 60 days and then several training objectives to display appropriate on a routine basis. In the future the behaviors, wipe his placesetting after meals, Qualified Professional will ensure clients thoroughly brush his teeth and tolerate wearing a

Review on 2/2/21 revealed these training objectives had not been reviewed to determine whether client #1 was making progress since

mask.

Personal Centered Plans are reviewed

and revised as necessary.

		MEDICAID SERVICES					M APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/GLIA				OMB NO). 0 9 38-0391
	F CORRECTION	IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	****	(X3) DATE COMF	SURVEY PLETED
		34G186	B, WING_	****	~~~~	02/	02/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		<u> </u>
BALLAW	AY STREET HOME			4795 STANLEY ROAD			
MOLLOW	AT STREET HUME			DURHAM, NC 27704			
(X4) ID		ATEMENT OF DEFICIENCIES	10	PROVIDER	R'S PLAN OF CORRECTION	<u> </u>	(X5)
PREFIX TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL -SC (DENTIFYING INFORMATION)	PREFIX		RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA		COMPLETION DATE
			1/1/0	DIVOQQ MERCK	DEFICIENCY)	A1 /=	DAIL
W 159	Continued From page	s 5	W 1	59	·		
	9/3/20.						
	B. Review on 2/1/21 o	of client #3's IPP dated					
	5/6/20 revealed she h	as current training	İ				
		rate of eating and tolerating					
	a mask.	,					
	Review on 2/2/21 revi	ealed these training					
		en reviewed to determine					
		making progress since					
	August 2020.						
		of client #4's IPP dated					
		as training objectives to	İ				
	refrain from physical a	iggression, to fold clothing,					
	recognize printed mer mask.	nus and tolerate wearing a					
	Review on 2/2/21 reve						
		en reviewed to determine					
		making progress since					
	October 2020.						
		th the qualified intellectual					İ
	disabilities professions					į	
		evealed there were no	İ			İ	
	recent progress notes	for these training programs				į	•
	rot clients #1, #3 and #	4. Additional interviews					
	the uncefional parter f	nave not been coming to or over 10 months because				-	****
	of the COVID-19 pand						#
	restrictions on staff go	ing between homes to		**		ľ	***************************************
	prevent the spread of	COVID-19.					***************************************
W 227	INDIVIDUAL PROGRA		W 22	7			
	CFR(s): 483.440(c)(4)		# # Au Au				**************************************
	The individual program	n plan states the specific					MANAGEM PARTY OF THE PARTY OF T
		o meet the client's needs,		1			AMAZINI

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		34G186	B. WING	YA	ر ا	(02/2024
NAME OF PROVIDER OR SUPPLIER HOLLOWAY STREET HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1795 STANLEY ROAD DURHAM, NC 27704	·····	/02/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP) DEFICIENCY)	IÚLD BE	(X5) COMPLETION DATE
W 227	as identified by the co	e 6 imprehensive assessment n (c)(3) of this section.	W 227			
	Based on observation interview, the facility faudit clients (#5) indivinctuded specific object communication needs comprehensive function finding is: Throughout observation staff used verbal cues #5 who is non-verbal supper at 5:55pm, start cued client #5 to come Staff C pointed the table dining room to eat. Throughout observation manager (RM) and staff care interventions.	identified in the conal assessment. The cons in the facility on :2/1/21 to communicate with client When it was time for ff C and staff D verbally to the table to supper. Ole and client 5 came to the cons on 2/2/21 the residence aff E verbally cued client #5 eat breakfast and to go to		A team meeting will be held to client #5 Communication Eval The HabilitationSpecialist will staff on results of team meet Qualified Professional will reverson Centered Plan with resofthe team meeting. The Clir Team will monitor through Interaction Assessments 2 tin week for 1 month and then or routine basis to ensure the obclient #5 are implemented as In the future the Qualified Prowill ensure Person Centered Intervention/objectives to addineeds.	luation. Il in-service ing. The vise the esults nical nes per n a pjective for perscribed. fessional	
	plan (IPP) dated 3/4/2 diagnosis of Autism an disabilities. Further rev	ient #5's individual program 0 revealed client #5 has a id moderate intellectual view of his IPP revealed he ble to communicate with				

communication attempts. The recommendations

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FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 34G18(B. WING 02/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4796 STANLEY ROAD HOLLOWAY STREET HOME DURHAM, NC 27704 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D D PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) W 227 Continued From page 7 W 227 from this evaluation included: encouraging staff to develop yes or no answers with client #5 when possible and use of a communication board to label items in client #5's living area as well as using picture and symbol based communication as much as possible. Interview on 2/2/21 with the qualified intellectual disabilities professional (QIDP) revealed despite recommendations from the speech therap st to develop training using picture communication for client #5, this has not been implemented. W 242 INDIVIDUAL PROGRAM PLAN W 242 CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the individual program plan (IPP) included objective training to address bathing, dressing and medication administration needs for 4 of 4 sampled clients (#1, #3, #4 and #5). The findings include: A. Review on 2/1/21 of client #1's individual program plan (IPP) dated 10/6/20 revealed a formal training objective to wash his face with

65% partial independence was completed on

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her water and disposed of her trash.

Review on 2/1/21 of client #3's individual program

identified in the area of medication administration.

inventory (ABI) dated 5/4/20 revealed in the area

plan (IPP) dated 5/6/20 revealed no training

Review on 2/2/21 of her adaptive behavior

independence in the areas of recognizing the

effects of her medications, no independence in

time of her medication, recognizing the side

of medication administration, she has no

recognizing items on the medication administration record (MAR) and no independence in naming her medications.

needs.

Person Centered Plan with results of the team meeting. The Clinical

Interaction Assessments 2 times per

routine basis to ensure the objective for

client #3 are implemented as perscribed

will ensure Person Centered Plans include

In the future the Qualified Professional

intervention/objectives to address client

week for 1 month and then on a

Team will monitor through

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revealed he has no independence in all areas of

bathing, brushing his teeth and requires

assistance with hand washing.

needs.

In the future the Qualified Professional

intervention/objectives to address client

will ensure Person Centered Plans include

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Review of several memorandums posted in the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 340186 8. WING 02/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4795 STANLEY ROAD HOLLOWAY STREET HOME DURHAM, NC 27704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 340 Continued From page 11 W 340 facility from Nursing and the residence manager (RM) which were undated indicated residential staff were trained in personal protection equipment (PPE) and preventing the spread of COVID-19. Further review of a memorandum from the Nursing department indicated all direct care staff were to wear full PPE (mask, facial shield and gown) when working with the clients in the facility at all times. Interview on 2/2/21 with the RM confirmed recently Nursing had changed the requirement of PPE wear and mandated that all direct care staff were to wear full PPE (mask, facial shield and gown) when working with the clients in the facility at all times. Interview on 2/2/21 with the facility nurse confirmed she had instructed direct care staff to wear full PPE (mask, facial shield and gown) when working with the clients in the facility at all times to prevent the spread of COVID-19 Lntil further notice. W 368 DRUG ADMINISTRATION W 368 CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the system of administrating medications as ordered was implemented. This affected 1 of 4 audit clients (#4) The finding is:

During interview with staff C prior to the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUI/IBER;	(X2) MULTIF A. BUILDING	LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		34G186	B. WING		02	/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	***************************************	/GALAUA :
LIMI I MINI				4795 STANLEY ROAD		
MOLLO44/	Y STREET HOME			DURHAM, NC 27704		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION
TAG	NEGOCKION GR	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	CATE
W 368	Continued From page	: 12	w ae	8 The DN will coordinate with	tha Dulmana	450/04
	medication administra	ation pass on 2/1/21 at		THE WAIT COOLD THE WILL	ine Primary	4/2/21
		that client #4's medication	ļ	Physician to ensure client #4		
		been ordered but had not		individuals received their me ordered to be administer as		
	been received from th	e pharmacy. As a result he	İ			
		oses of this medication.		prevent delay în implementa		
		firmed this medication for		Monitoring administrating me	saication	
		to be administered at 8am		will take place through	than Olimbant	
	and 6pm every day.			chart reviews completed by the Team on a quartely basis. In		
	Review on 2/1/21 of the			the RN will coordinate with the		
		(MAR)for client #4 for		to ensure all individual medic	retione ara	
		d client #4 had missed his		ordered on time.	various are	
		ution on the following dates:		oracies on mic.		
	1/1/21 at 8am	and the tollowing dates.				
-	1/1/21 at 6pm					
ŀ	1/2/21 at 8am					
•	1/3/21 at 8am					
	1/3/21 at 6pm		İ			
	1/4/21 at 8am					j
	1/4/21 at 6pm					
	1/5/21 at at 8am				,	
	1/5/21 at 6pm					
		ne February MAR revealed			ļ	
	client #4 had missed t	he following doses:			į	
	2/1/21 at 8am					
	2/1/21 at 6pm				į	
	Interview on 2/1/21 wi	th staff C indicated this				
		ed but had not arrived from			ļ	
	the pharmacy. Further					
		ppened twice since since				***************************************
		nis medication. Additional				***************************************
		e facility nurse had been			İ	
		had not arrived from the			ĺ	
	pharmacy.					
	Interview on 2/2/21 wit	th the facility nurse				
			1	,		ŧ

confirmed she had been notified the medication

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/04/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 34G186 B. WING 02/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4795 STANLEY ROAD **HOLLOWAY STREET HOME** DURHAM, NC 27704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 368 Continued From page 13 W 368 had not arrived from the pharmacy. Further interview confirmed the back up pharmacy could not fill this medication either. W 369 DRUG ADMINISTRATION W 369 The RN will coordinate with the Primary 4/2/21 CFR(s): 483.460(k)(2) Physician to ensure client #4 and all individuals received their medication as The system for drug administration must assure ordered to be administer as written to that all drugs, including those that are prevent delay in implementation. self-administered, are administered without error. Monitoring Medication Administration will take place through chart reviews This STANDARD is not met as evidenced by: completed by the ClinicalTeam on a Based on observations, record review and quartely basis. In the future the RN will interviews, the facility failed to ensure client #4's coordinate with the Physician medications were administered without error. to ensure all individual medications are This affected 1 of 4 clients (#4) observed ordered on time and given as prescribed receiving medications. The findings include: to prevent error. A. During interview with staff C prior to the medication administration pass on 2/1/21 at 4:05pm he explained that client #4's medication Trictrates solution had been ordered but had not been received from the pharmacy. As a result he had missed several doses of this medication. Further interview confirmed this medication for client #4 was ordered to be administered at 8am and 6pm every day. During observations on 2/1/21 from 3:15pm until 6:15pm client #4 did not receive Tricitrate Solution as ordered by the physician.

B. During observations of the medication

administration pass on 2/2/21 at 7:26am client #4 received Phenobarbitol 32.4 mg. (1), Vimpat 20 mg. (1), Venlafexine 75 mg. (1), Macrobid 100mg. 910, Naltrexone 50mg. (1), Multivitamin 91), Metoprolof Succinate 100mg. (1), Keppra 750

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		34G18€	B. WING			2/02/2021	
	ROVIDER OR SUPPLIER AY STREET HOME		47	REET ADDRESS, CITY, STATE, ZIP CODE 95 STANLEY ROAD JRHAM, NC 27704		210212021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE'S Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	N SHOULD BE COMPLETION BATE		
W 369	Client #4 did not rece Lactulose solution 10/10/10/10/10/10/10/10/10/10/10/10/10/1	ive Tricitrate Solution, mg. or Systane eye drops. The physician orders dated evealed Tricitrate Solution with meals for kidneys, mix r. May use thickening electar consistency. Ordered additional review of the d 1/11/21 also confirmed g. (1), Vimpat 20 mg. (1), Macrobid 100mg. 910, Multivitamin 91), 100mg. (1), Keppra 750 (1), Vitamin D3 4,000, mg. and Systane eye drops the facility nurse an orders for client #1 were ould have received am and 6pm. Further ent #4 should receive mg./25 ml. and Systane eye	W 369				

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FORM APPROVED



RHA Health Services, LLC 2527 E. Lyon Station Rd Creedmoor, NC 27522 Phone: 919-528-2558

Fax: 919-528-2971

FAX TRANSMISSION

CONFIDENTIAL HEALTH INFORMATION ENCLOSED

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