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 _____	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLOWAY STREET HOME	4785 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
E 015	Subsistence Needs for Staff and Patients 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 limited to the following: (A) Food, water, medical, and	E 015		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 02.15.21

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E 015	Continued From page 1 pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on observation, record verification and interview, the facility failed to assure the emergency plan (EP) was implemented specific to the subsistence needs of the group home. The finding is: Observation on 2/1/21 at 5:20pm of the the kitchen pantry of the group home revealed two plastic storage bins labeled "Emergency Food Supply" that were empty. Additional observation of the kitchen pantry revealed 1 case of bottled water on the floor in the pantry. Review of the facility EP on 2/1/21 revealed there was to be a supply of emergency food items relative to the subsistence needs of the group home. 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.	E 015	The QP will in-service Residential Team Leader on the importance of maintaining the food pantry including the Emergency FoodSupply bin are full stock/equipped at all times. Monitoring the Emergency Preparedness Polices will occur through 2 Evironment Assessments per week for the next month by the clinical staff and then on a routine basis. In the future the QP will assure the Emergency Plan is in implemented specific to required emergency food and supplies	4/2/21

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E 015	Continued From page 2 Interview on 2/2/21 with the RM confirmed the emergency food supply had not been replenished since January 2021.	E 015		
W 126	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: Review of client #3's individual program plan (IPP) dated 5/6/20 revealed she had a money management objective to identify a quarter with 85% accuracy for 2 consecutive review periods. No data could be located for this objective in the facility. Additional review of the IPP did not reveal any additional training in the area of money management or budgeting. Interview with staff A on 2/1/21 this objective for client #3 is not being trained in the facility. Further interview confirmed the clients have not been attending their vocational setting for over 11 months due to the current COVID-19 Pandemic. Review on 2/2/21 of her adaptive behavior inventory (ABI) dated 4/2/20 revealed client #3 requires partial assistance in all areas of money management and budgeting.	W 126	A team meeting will be held to discuss client #3 skills relevent to Money-Management. The Habilitation Specialist will in-service staff on results of team meeting. The Qualified Professional will revise the Person Centered Plan with results of the team meeting. The Clinical Team will monitor client #3 Money-Management objective through Interaction Assessments 2 times per week for 1 month and then on a routine basis.In the future the Qualified Professional will ensure Person Centered Plans include intervention to address client needs.	4/2/21

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W 126	Continued From page 3 Interview on 2/2/21 with the qualified intellectual disabilities professional (QIDP) and the habilitation specialist revealed the objective to recognize a quarter was completed but that no other money management training had been identified for client #3.	W 126		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure privacy for 2 of 3 audit clients (#4 and #5). The finding is: During observations in the facility on 2/1/21 staff C took client #4 to the bathroom at 5:35pm and left him sitting on the toilet with the door open. Client #4 was naked from the waist down. Staff D took client #5 to the bathroom at 5:40pm and left him in the other bathroom toileting with the door open. Both bathroom doors were open. During this time, female client #3 walked down the hallway to her bedroom to put away an item and she walked back past the bathroom doors. Review on 2/1/21 of client #5's individual program plan (IPP) dated 3/4/20 revealed he has privacy guidelines OSG#2 for staff to remind him to close the bathroom door to safeguard his privacy during toileting. Review on 2/2/21 of client #5's adaptive behavior	W 130	A team meeting will be held to discuss clients #4, #5 skills revelent to privacy and toileting. The habilitation Specialist will in-service staff on results of team meeting. The Qualified Professional will revise the Person Centered Plan with result of team meeting. The Clinical Team will monitor Client #4,#5 privacy and toileting objective Interactive Assessments 2 times per week for 1 month and then on a routine basis. In the future the Qualified Professional will ensure Person Centered Plan include rights for people supported and ensuring privacy during treatment and care of personal needs.	4/2/21

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W 130	Continued From page 4 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 130		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the qualified intellectual disabilities professional (QIDP) failed to ensure clients' individual program plans (IPP's) were reviewed and revised as necessary. This affected 3 of 4 audit clients (#1, #3 and #4). The findings are: A. Review on 2/2/21 of client #1's individual program plan (IPP) dated 10/6/20 revealed several training objectives to display appropriate behaviors, wipe his placesetting after meals, thoroughly brush his teeth and tolerate wearing a mask. Review on 2/2/21 revealed these training objectives had not been reviewed to determine whether client #1 was making progress since	W 159	A,B,C, The Administrator will in-service the Qualified Professional and Habilitation Specialist on reviewing and monitoring clients Person Supported Plans on a monthly basis and implementing revisions as necessary. The Qualified Professional and Habilitation Specialist will be required to submit a scheduled to the Administrator which will include assessments in the home and monitoring program progress. The Administrator will monitor on a weekly basis to ensure scheduled monitoring occurs for 60 days and then on a routine basis. In the future the Qualified Professional will ensure clients Personal Centered Plans are reviewed and revised as necessary.	4/2/21

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W 159	Continued From page 5 9/3/20. B. Review on 2/1/21 of client #3's IPP dated 5/6/20 revealed she has current training objectives to slow her rate of eating and tolerating a mask. Review on 2/2/21 revealed these training objectives had not been reviewed to determine whether client #3 was making progress since August 2020. C. Review on 2/1/20 of client #4's IPP dated 3/24/20 revealed he has training objectives to refrain from physical aggression, to fold clothing, recognize printed menus and tolerate wearing a mask. Review on 2/2/21 revealed these training objectives had not been reviewed to determine whether client #3 was making progress since October 2020. Interview on 2/2/21 with the qualified intellectual disabilities professional (QIDP) and the habilitation specialist revealed there were no recent progress notes for these training programs for clients #1, #3 and #4. Additional interviews confirmed the clients have not been coming to the vocational center for over 10 months because of the COVID-19 pandemic and there are restrictions on staff going between homes to prevent the spread of COVID-19.	W 159		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs,	W 227		

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W 227	Continued From page 6 as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure for 1 of 3 audit clients (#5) individual program plan (IPP) included specific objectives to address his communication needs identified in the comprehensive functional assessment. The finding is: Throughout observations in the facility on 2/1/21 staff used verbal cues to communicate with client #5 who is non-verbal. When it was time for supper at 5:55pm, staff C and staff D verbally cued client #5 to come to the table to supper. Staff C pointed the table and client 5 came to the dining room to eat. Throughout observations on 2/2/21 the residence manager (RM) and staff E verbally cued client #5 to come to the table to eat breakfast and to go to the medication room to get his medication. Review on 2/1/21 of client #5's individual program plan (IPP) dated 3/4/20 revealed client #5 has a diagnosis of Autism and moderate intellectual disabilities. Further review of his IPP revealed he is non-verbal and is able to communicate with gestures, facial expressions. Review on 2/2/21 of client #5's communication evaluation dated 10/21/20 revealed client #5's skills are not functional for his current living environment and that he does not make communication attempts. The recommendations	W 227	A team meeting will be held to discuss client #5 Communication Evaluation. The HabilitationSpecialist will in-service staff on results of team meeting. The Qualified Professional will revise the Person Centered Plan with results of the team meeting. The Clinical Team will monitor through Interaction Assessments 2 times per week for 1 month and then on a routine basis to ensure the objective for client #5 are implemented as perscribed. In the future the Qualified Professional will ensure Person Centered Plans include intervention/objectives to address client needs.	4/2/21

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W 227	Continued From page 7 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 therapist to develop training using picture communication for client #5, this has not been implemented.	W 227		
W 242	INDIVIDUAL PROGRAM PLAN 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	W 242		

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W 242	Continued From page 8 3/30/20. Further review of the IPP did not reveal any additional objective to address client #1's self help needs. Review on 2/2/21 of client #1's adaptive behavior inventory (ABI) dated 9/4/20 revealed client #1 has no independence in the following areas: applying deodorant, all areas of bathing and shampooing his hair. Client #1 needs assistance with washing his hands with soap and drying his hands with a towel. Interview on 2/2/21 with the qualified intellectual disabilities professional (QIDP) and habilitation specialist confirmed no other training objectives had been developed for client #1 despite his lack of independence in bathing and washing his hands. B. During observation of the medication administration pass on 2/2/21 at 7:05am client #3 was told what medications she was receiving and then she punched out Vitamin D3 (1) pill and Oscal Vitamin D 500 mg. (1) pill. Client #3 poured her water and disposed of her trash. Review on 2/1/21 of client #3's individual program plan (IPP) dated 5/6/20 revealed no training identified in the area of medication administration. Review on 2/2/21 of her adaptive behavior inventory (ABI) dated 5/4/20 revealed in the area of medication administration, she has no independence in the areas of recognizing the time of her medication, recognizing the side effects of her medications, no independence in recognizing items on the medication administration record (MAR) and no independence in naming her medications.	W 242	(A)A team meeting will be held to discuss client #1 Self help needs. The HabilitationSpecialist will in-service staff on results of team meeting. The Qualified Professional will revise the Person Centered Plan with results of the team meeting. The Clinical Team will monitor through Interaction Assessments 2 times per week for 1 month and then on a routine basis to ensure the objective for client #1 are implemented as perscribed. In the future the Qualified Professional will ensure Person Centered Plans include intervention/objectives to address client needs. (B).A team meeting will be held to discuss client #3 Medication Administration. The HabilitationSpecialist will in-service staff on results of team meeting. The Qualified Professional will revise the Person Centered Plan with results of the team meeting. The Clinical Team will monitor through Interaction Assessments 2 times per week for 1 month and then on a routine basis to ensure the objective for client #3 are implemented as perscribed. In the future the Qualified Professional will ensure Person Centered Plans include intervention/objectives to address client needs.	4/2/21 4/2/21

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W 242	Continued From page 9 Interview on 2/2/21 with the QIDP and the habilitation specialist revealed client #3 has not been considered for training in medication administration despite the fact she has no independence in this area. C. Review on 2/1/21 of client #4's IPP dated 3/24/20 revealed he had met criteria for a formal training objective to wash the front of his body on 6/26/19. Further review of the IPP did not reveal any additional objective to address client #4's self help needs. Review on 2/2/21 of client #4's ABI dated 2/28/20 revealed he requires partial assistance with all areas of washing his hands, face and all areas of bathing, shampooing his hair and brushing his teeth. Interview on 2/2/21 with the QIDP and habilitation specialist confirmed no other training objectives had been developed for client #4 despite his lack of independence in bathing ,toothbrushing and washing his hands. D. Review of client #5's IPP dated 3/4/20 revealed he completed criteria for completion of an objective to wash his face with 50% partial physical prompts for 2 consecutive review periods on 9/30/20. Further review of the IPP did not reveal any additional objective to address client #5"s self help needs. Review on 2/2/21 of client #5's ABI dated 2/7/20 revealed he has no independence in all areas of bathing, brushing his teeth and requires assistance with hand washing.	W 242	C.A team meeting will be held to discuss client #4 Self-Help needs. The HabilitationSpecialist will in-service staff on results of team meeting. The Qualified Professional will revise the Person Centered Plan with results of the team meeting. The Clinical Team will monitor through Interaction Assessments 2 times per week for 1 month and then on a routine basis to ensure the objective for client #4 are implemented as perscribed. In the future the Qualified Professional will ensure Person Centered Plans include intervention/objectives to address client needs. (D).A team meeting will be held to discuss client #5 Self Help needs. The HabilitationSpecialist will in-service staff on results of team meeting. The Qualified Professional will revise the Person Centered Plan with results of the team meeting. The Clinical Team will monitor through Interaction Assessments 2 times per week for 1 month and then on a routine basis to ensure the objective for client #5 are implemented as perscribed. In the future the Qualified Professional will ensure Person Centered Plans include intervention/objectives to address client needs.	4/2/21

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W 242	Continued From page 10 Interview on 2/2/21 with the QIDP and habilitation specialist confirmed no other training objectives had been developed for client #5 despite his lack of independence in bathing ,toothbrushing and washing his hands.	W 242		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the nurse failed to ensure competency when training staff to prevent cross contamination, while providing services to 5 of 5 clients (#1, #2, #3, #4 and #5) . The finding is : During observations at the facility on 2/1/21 between 3:15pm-6:05pm, staff C kept his face mask below his nose several times. At one time while he was sitting in the living area next to client #1 and then again in the dining area during supper at 5:55pm. During observations in the facility on 2/2/21 staff A came into work, clocked in, was screened wearing a mask and a gown. During observations on 2/2/21 from 7:00am-7:45am during meal preparation in the kitchen and during dining, staff A did not wear a face shield. Review of several memorandums posted in the	W 340	The responsbile nurse will inservice all staff on properly of wearing require PPE. Monitoring will be completed through the Interaction Assessments 2 times per week to ensue staff are wearing PPE correctly and Quarterly Nursing Assessment. In the future nursing will ensure all staff are trained on information relvent of using the PPE.	4/2/21

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W 340	Continued From page 11 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 until further notice.	W 340		
W 368	DRUG ADMINISTRATION 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	W 368		

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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 368	Continued From page 12 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. Review on 2/1/21 of the medication administration record (MAR)for client #4 for January 2021 revealed client #4 had missed his doses of Tricitrate solution on the following dates: 1/1/21 at 8am 1/1/21 at 6pm 1/2/21 at 8am 1/3/21 at 8am 1/3/21 at 6pm 1/4/21 at 8am 1/4/21 at 6pm 1/5/21 at at 8am 1/5/21 at 6pm Review on 2/1/21 of the February MAR revealed client #4 had missed the following doses: 2/1/21 at 8am 2/1/21 at 6pm Interview on 2/1/21 with staff C indicated this medication was ordered but had not arrived from the pharmacy. Further interview with staff C confirmed this has happened twice since since client #4 had started this medication. Additional interview confirmed the facility nurse had been notified the medication had not arrived from the pharmacy. Interview on 2/2/21 with the facility nurse confirmed she had been notified the medication	W 368	The RN will coordinate with the Primary Physician to ensure client #4 and all individuals received their medication as ordered to be administer as written to prevent delay in implementation. Monitoring administrating medication will take place through chart reviews completed by the Clinical Team on a quartely basis. In the future the RN will coordinate with the Physician to ensure all individual medications are ordered on time.	4/2/21

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 _____	02/02/2021

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 368	Continued From page 13 had not arrived from the pharmacy. Further interview confirmed the back up pharmacy could not fill this medication either.	W 368		
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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4's medications were administered without error. This affected 1 of 4 clients (#4) observed receiving medications. The findings include: 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), Metoprolol Succinate 100mg. (1), Keppra 750	W 369	The RN will coordinate with the Primary Physician to ensure client #4 and all individuals received their medication as ordered to be administer as written to prevent delay in implementation. Monitoring Medication Administration will take place through chart reviews completed by the ClinicalTeam on a quartely basis. In the future the RN will coordinate with the Physician to ensure all individual medications are ordered on time and given as prescribed to prevent error.	4/2/21

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 _____	02/02/2021

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(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	Continued From page 14 mg. (1), Vitamin D 2,00 (1), Vitamin D3 4,000 (1). Client #4 did not receive Tricitrate Solution, Lactulose solution 10mg. or Systane eye drops. Review on 2/2/21 of the physician orders dated 1/11/21 for client #4 revealed Tricitrate Solution take 15 ml. twice daily with meals for kidneys, mix with 8 ounces of water. May use thickening powder to thicken to nectar consistency. Ordered at 8am and 6pm daily. Additional review of the physician orders dated 1/11/21 also confirmed Phenobarbitol 32.4 mg. (1), Vimpat 20 mg. (1), Venlafexine 75 mg. (1), Macrobid 100mg. 910, Naltrexone 50mg. (1), Multivitamin 91), Metoprolol Succinate 100mg. (1), Keppra 750 mg. (1), Vitamin D 2,00 (1), Vitamin D3 4,000, Lactulose solution 10mg. and Systane eye drops to be given at 8am. Interview on 2/2/21 with the facility nurse confirmed the physician orders for client #4 were current and that he should have received Tricitrate Solution at 8am and 6pm. Further interview confirmed client #4 should receive Lactulose solution 10mg./25 ml. and Systane eye drops to both eyes to be given at 8am.	W 369		

RHA
HEALTH SERVICES, LLC

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

To:	Kimberly McCaskill	Fax:	919 715-8078
From:	Penny Johnson	Date:	3/16/21
Re:		Pages:	(Including Cover)
CC:			16

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Additional Comments: Surrey POC Agency RD