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 _____	10/12/2021

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
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure the interdisciplinary team completed preliminary accurate assessments within 30 days after admission. This affected 1 newly admitted audit client (#2). The finding is: Review of client #2's record revealed he was admitted to the facility on 7/19/21. Further review of his record revealed the individual program plan (IPP) meeting was held on 8/18/21. Client #2 is currently being treated with Abilify and Zoloft. Review of his preliminary evaluations revealed he was missing a psychiatric evaluation. During an interview on 10/12/21 with the Executive Director confirmed that the team had not completed a psychiatric evaluation for client #2 since his admission on 7/19/21.	W 210		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review, documentation and interviews, the facility failed to ensure data was	W 252		

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

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 _____	10/12/2021

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
W 252	Continued From page 1 documented correctly. This affected 3 of 3 audit clients (#2, #4 and #6). The findings are: A. Review on 10/12/21 of client #4's goals revealed for "Identifies side effects of medications using manual signs" for the month of October 2021 revealed data missing for the following days: October 4 - 10. B. Review on 10/12/21 of client #6's goals revealed "oral hygiene care checklist (1st shift FRONT/2nd shift BACK)" for the month of October 2021 revealed data missing for the following days: October 1 - 4 and October 8 - 10. C. Review on 10/12/21 of client #2's goals revealed "answer questions related to med administration," "correctly answer personal information questions" and "brush teeth using electric toothbrush" for the month of October 2021 revealed no data had been recorded. Review of client #2's "oral hygiene care checklist (1st shift FRONT/2nd shift BACK)" for the month of October revealed data was missing for the following days: October 1-10. During an interview on 10/12/21 with the residential supervisor (RS) revealed that the habilitation specialist is responsible for data collection, goals and making sure data is up to date. The residential manager confirmed that data records were incomplete at this time.	W 252		
W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be	W 289		

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 _____	10/12/2021

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
W 289	Continued From page 2 incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure the use of systematic interventions to manage clients inappropriate behaviors were incorporated into the client's individual program plan (IPP). This affected 1 of 3 audit clients (#2). The finding is: Observation in the home on 10/11- 12/21 revealed an alarm on client #2's bedroom door that sounded each time the door was opened. During an interview on 10/21/21, Staff B stated the alarm is on client #2's bedroom door so staff can keep track of where he is at. Additional interview revealed client #2 will go into the other clients' bedrooms. Review on 10/12/21 of client #2's record revealed a behavior intervention plan (BIP) dated 8/18/2021. The BIP states the need for "eyes on supervision with periodic 1:1 monitoring due to his history of elopement at other placements". The BIP does not mention the use of a door alarm. During an interview on 10/12/21 with the Executive Director revealed the use of a door alarm was not incorporated into client #2's BIP.	W 289		
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	W 340		

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 _____	10/12/2021

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
W 340	Continued From page 3	W 340		

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, documentation and interview, nursing services failed to ensure that staff were sufficiently trained in the taking the temperature of visitors in regards to COVID-19 protocol and the proper wearing of face masks. This potentially effected all clients (#1, #2, #3, #4, #5 and #6) residing in the facility. The findings are:

A. During morning observations at the day program on 10/11/21 at 11:32am, Staff D greeted the two surveyors when they walked in. Further observations revealed the two surveyors temperatures were not taken. Staff D only asked the two surveyors if they had any exposure to anyone with COVID-19.

B. During morning observations at the home on 10/12/21 at 6:27am, Staff B told the two surveyors to come inside. Further observations revealed the two surveyors temperatures were not taken or any questions asked. Further observations revealed there was a thermometer and a book for visitors to fill out on a table in the living room.

Review on 10/12/21 of the facility's COVID-19 screening assessment tool form asks the following questions: "1. Have you been or come into contact with anyone that has traveled internationally in the last 30 days? 2. Have you been in close contact with another person who has been diagnosed with/under investigation for COVID-19? 3. Do you have a cough, fever, or shortness of breath? What is your temperature?

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 _____	10/12/2021

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
W 340	Continued From page 4 4. Have you had the flu or flu-like symptoms in the last 30 days". Review on 10/12/21 of a memo concerning visitation guidelines dated 7/10/21 states, "All visitors should be screened via COVID-19 screening tool". During an interview on 10/12/21, the residential supervisor (RS) revealed all visitors that enter into the home are to have their temperature taken. During an interview on 10/12/21, the executive director (ED) revealed any time a visitor comes into the facility their temperature is to be taken. Further interview revealed all staff have been trained to take the temperature of all visitors. C. During observations throughout the survey on 10/11 - 12/21 Staff A was observed wearing their face mask below their nose or not covering their face at all. Further observations revealed on 10/12/21 Staff B was not wearing a face mask when he had the two surveyors entering the home. Staff B was observed putting on their face mask on at 6:28am. During an interview on 10/12/21, the RS revealed staff are to wear a face mask while working in the home. Further interview revealed the face mask should cover the nose. Review on 10/12/21 of memo concerning safety precautions dated 8/30/21 stated, "Effectively immediately, upon entering the group home ALL staff should be wearing their mask...." Review on 10/12/21 of an inservice dated 7/29/21	W 340		

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 _____	10/12/2021

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
W 340	Continued From page 5 revealed the following was discussed: " "Masks must be worn at all times in the home...." During an interview on 10/12/21, the ED revealed whenever staff are wearing a face mask it must cover the nose and mouth. Further interview all staff have been trained.	W 340		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained locked except when being administered. The finding is: During observations of medication administration in the home on 10/12/21 at 7:25am, surveyor was standing outside medication room door and holding medication packs to record information from client #5's medication pass. Staff A locked the medication door and left medication packs in the surveyor's hand while she went to get the next client for medication pass. During an interview on 10/12/21 with Staff A revealed they had been trained to lock medications in the medication closet before leaving the area. During an interview on 10/12/21 with the residential supervisor confirmed medications should be locked up prior to leaving the medication area.	W 382		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1)	W 441		

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 _____	10/12/2021

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
W 441	Continued From page 6 and under varied conditions to- This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure fire drills were conducted at varying times and conditions. This potentially affected all clients residing in the home (client's #1, #2, #3, #4, #5 and #6). The finding is: Review on 10/12/2021 of facility fire drill reports for November 2020- October 2021 revealed second shift drills were conducted at 7:37pm, 8:00pm, 7:22pm, 7:01pm, 7:45pm, 8:45pm, 6:15pm, 9:50pm, 9:30pm, 9:00pm and 12:29am. The fire drills were not conducted during varied times or during deep sleeping hours. During an interview on 10/12/21 with the residential supervisor (RS) revealed the fire drills are scheduled by the facility support coordinator and sent out to the homes in a memo. The RS acknowledged no fire drills were conducted during deep sleep hours between 1am and 4am.	W 441		