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 _____	02/01/2022

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 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 interview, the facility failed to ensure 2 of 3 audit clients (#2 and #4) were taught to manage their financial affairs to the extent of their capabilities. The findings are: A. Review on 1/31/22 of client #2's individual program plan (IPP) dated 11/9/21 revealed he needs assistance managing his finances and that he has been adjudicated incompetent and appointed a legal guardian to act on his behalf. Review of his adaptive behavior inventory (ABI) dated 10/6/21 revealed client #2 has no independence in the following areas: depositing money into checking or savings. He requires assistance making change. Review on 1/31/22 of his current training objectives revealed he has training identified in wearing a mask out in public, exercising for 30 minutes and a behavior support program (BSP) to decrease property destruction and physical aggression. Interview on 2/1/22 with the qualified intellectual disabilities professional (QIDP) revealed the team has not identified training for client #2 in the area of money management, although his ABI identified several areas in money management with which he requires assistance from staff. B. Review on 1/31/22 of client #4's IPP dated 5/11/21 revealed she requires assistance with	W 126	A. A Team meetingwill be held to discuss client #2 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 #2 Money Management objective through Interaction Assessment 2 times per week for 1 month and then on a rountine basis. In the future the Qualified Professional will ensure the Person Centered Plans include intervention to address client needs.	4/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 02.10.22

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.

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W 126	Continued From page 1 money management. Review on 1/31/22 of her ABI dated 4/16/21 revealed she has no independence in the following areas: completing a check, depositing money into checking or savings. She requires assistance from staff to recognize a half dollar, making change keeping up with her money over the course of a day or a week. Review on 1/31/22 of client #4's current training objectives revealed the following: providing information about Fluoxetine in the area of medication administration, identifying hazard signs and preparing meat in dishes in the oven. Interview on 2/1/22 with the qualified intellectual disabilities professional (QIDP) revealed the team has not identified training for client #4 in the area of money management, although her ABI identified several areas in money management with which she requires assistance from staff.	W 126	B. A Team meetingwill be held to discuss client #4 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 #4 Money Management objective through Interaction Assessment 2 times per week for 1 month and then on a rountine basis. In the future the Qualified Professional will ensure the Person Centered Plans include intervention to address client needs.	4/1/22
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 and confirmed by interview with staff, the facility did not provide data as prescribed by 2 of 3 audit clients (#2 and #4) formal objective programs. The findings are: A. Review on 1/31/22 of client #2's formal	W 252		

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W 252	Continued From page 2 objective programs revealed the following: tolerating wearing a mask in public, exercising for 30 minutes and displaying no physical aggression or property destruction for 12 consecutive months. Review on 1/31/22 in the facility for the current data for these programs revealed there was no data for the month of January 2022 for any of client #2's written training programs. Interview on 1/31/22 with residential manager (RM) revealed the habilitation specialist has not put the new data sheets in client #2's training book and there were not training sheets for the current month of February 2022. B. Review on 1/31/22 of client #4's IPP dated 5/11/21 revealed the following current training objectives: providing information about Fluoxetine in the area of medication administration, identifying hazard signs and preparing meat in dishes in the oven. Review on 1/31/22 in the facility for the current data for these programs revealed there was no data for the month of January 2022 for any of client #4's written training programs. Interview on 1/31/22 with residential manager (RM) revealed the habilitation specialist has not put the new data sheets in client #4's training book and there were not training sheets for the current month of February 2022. Interview on 2/1/22 with the qualified intellectual disabilities professional (QIDP) revealed there was not available data for clients #2 and #4 for January 2022.	W 252	The QP will in-service the Habilitation Specialist regarding tracking and monitoring of habilitation goals. A review of all formal programing goals for client #2 and all people in the home with be completed to ensure progress is being monitored and changes are taking place as needed. QP will go into the home 1x week and monitor to ensure data sheets for all objectives are in place. Monitoring will occure through Core Team Meetings and the Chart Review process. In the future, the Interdisciplinary Team will ensure all goals are being discontinued or modified as progress is made. B. The QP will in-service the Habilitation Specialist regarding tracking and monitoring of habilitation goals. A review of all formal programing goals for client #4 and all people in the home with be completed to ensure progress is being monitored and changes are taking place as needed. QP will go into the home 1x week and monitor to ensure data sheets for all objectives are in place. Monitoring will occure through Core Team Meetings and the Chart Review process. In the future, the Interdisciplinary Team will ensure all goals are being discontinued or modified as progress is made.	4/1/22 4/1/22

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W 254	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that contribute to an overall understanding of the client's ongoing level and quality of functioning. This STANDARD is not met as evidenced by: Based on record review and interview the Qualified Professional (QP) failed to review the written training programs for 2 of 3 audit clients (#2 and #4). The findings are: A. Review on 1/31/22 of client #2's individual program plan (IPP) dated 11/9/21 revealed the following formal objective programs: tolerating wearing a mask in public, exercising for 30 minutes and displaying no physical aggression or property destruction for 12 consecutive months. Review on 1/31/22 of the program progress summaries for these programs revealed they had not been reviewed since September 2021 to determine if client #2 was making progress on his objectives. Interview on 2/1/22 with the qualified intellectual disabilities professional (QIDP) revealed there had not been reviews of client #2's programs since September 2021. B. Review on 1/31/22 of client #4's IPP dated 5/11/21 revealed the following written formal training objectives: providing information about Fluoxetine in the area of medication administration, identifying hazard signs and preparing meat in dishes in the oven. Review on 1/31/22 of the program progress summaries for these programs revealed they had not been reviewed since September 2021 to	W 254	A. The QP will in-service the Habilitation Specialist regarding tracking and monitoring of habilitation goals. A review of all formal programing goals for client #2 and all people in the home with be completed to ensure progress is being monitored and changes are taking place as needed. QP will go into the home 1x week and monitor to ensure data sheets for all objectives are in place. Monitoring will occure through Core Team Meetings and the Chart Review process. In the future, the Interdisciplinary Team will ensure all goals are being discontinued or modified as progress is made. The QP will in-service the Habilitation Specialist regarding tracking and monitoring of habilitation goals. A review of all formal programing goals for client #4 and all people in the home with be completed to ensure progress is being monitored and changes are taking place as needed. QP will go into the home 1x week and monitor to ensure data sheets for all objectives are in place. Monitoring will occure through Core Team Meetings and the Chart Review process. In the future, the Interdisciplinary Team will ensure all goals are being discontinued or modified as progress is made.	4/1/22 4/1/22

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W 254	Continued From page 4 determine if client #4 was making progress on her objectives. Interview on 2/1/22 with the qualified intellectual disabilities professional (QIDP) revealed there had not been reviews of client #4's programs since September 2021.	W 254		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interviews, the specially constituted committee, known as the Human Rights Committee (HRC), failed to review, approve and monitor programs designed to manage inappropriate behavior for 2 of 3 sampled clients (#2 and #4). The findings are: A. Review on 1/31/22 of client #2's individual program plan (IPP) dated 11/9/21 revealed has had been adjudicated incompetent and that his parents were assigned as his legal guardians. Review on 1/31/22 of client #2's behavior support program(BSP) dated 1/29/21 revealed this program was developed to address client #2's target behaviors of physical aggression and property destruction. Further review of this program revealed it incorporated the use of Abilify 12.5 mg. daily. Review on 1/31/22 of client #2's BSP consent revealed there was no HRC review of this	W 262	A. The QP will obtain all consents with all necessary guardian & HRC signatures and dates for client #2. The Clinical Team will monitor to ensure all proper signatures are on each consent through regular Peer Chart Reviews conducted at least quarterly review. In the future, the Qualified Professional will ensure that all restrictive BSP have written informed consent.	4/1/22

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W 262	Continued From page 5 program. Interview on 2/1/22 with the qualified intellectual disabilities professional (QIDP) revealed there was not documentation that this program had been reviewed by the HRC committee. B. Review on 1/31/22 of client #4's IPP dated 5/11/21 revealed she has been adjudicated incompetent and that her parents are her legal guardians. Further review on 1/31/22 of the IPP revealed client #4 has a BSP to not issue negative remarks for 6 consecutive months. This program incorporated the use of Seroquel, Prozac and Tegretol. Review of the BSP consent revealed it was signed by her legal guardians on 11/18/21. There was no review by the HRC for this program. Interview on 2/1/22 with the qualified intellectual disabilities professional (QIDP) revealed there was not documentation that this program for client #4 had been reviewed by the HRC committee.	W 262	B. The QP will obtain all consents with all necessary guardian & HRC signatures and dates for client #4. The Clinical Team will monitor to ensure all proper signatures are on each consent through regular Peer Chart Reviews conducted at least quarterly review. In the future, the Qualified Professional will ensure that all restrictive BSP have written informed consent.	4/1/22
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 3 audit clients	W 263		

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W 263	Continued From page 6 (#2). The finding is: Review on 1/31/22 of client #2's individual program plan (IPP) dated 11/9/21 revealed has had been adjudicated incompetent and that his parents were assigned as his legal guardians. Review on 1/31/22 of client #2's behavior support program(BSP) dated 1/29/21 revealed this program was developed to address client #2's target behaviors of physical aggression and property destruction. Further review of this program revealed it incorporated the use of Abilify 12.5 mg. daily. Review on 1/31/22 of client #2's BSP consent revealed the last written consent for client #2's previous BSP was on 3/26/18 with a written note on the consent that it expired twelve months from the time it was signed. Interview on 2/1/22 with the qualified intellectual disabilities professional (QIDP) revealed there was not written informed consent from the legal guardian for his BSP.	W 263	The QP will obtain all consents with all necessary guardian & HRC signatures and dates for client #2. The Clinical Team will monitor to ensure all proper signatures are on each consent through regular Peer Chart Reviews conducted at least quarterly review. In the future, the Qualified Professional will ensure that all restrictive BSP have written informed consent.	4/1/22
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on observation, record review and confirmed by interviews with staff, the facility failed to show evidence fire drills were conducted quarterly for each shift of personnel. The findings are: Review on 1/31/22 of the facility fire drills revealed from May 2021-October 2021 there was	W 440		

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	34G116	A. BUILDING _____ B. WING _____	02/01/2022

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W 440	Continued From page 7 only one fire drill held on 8/6/21 at 10:42am. Observations on 1/31/22 revealed the facility has an installed sprinkler system. Interview on 1/31/22 with the residential manager revealed the computer system was down that linked the fire alarm to the Durham County Fire Department so the facility went to a fire watch system during May-October 2021 where the facility direct care staff walked the hallways of the facility every hour and documented whether or not they smelled smoke. The RM also provided documentation of this fire watch system where the direct care staff documented their observations hourly from May 2021-October 2021. Further interview revealed there were no fire drills from May-October 2021 except for the drill that was located on 8/6/21 at 10:42am. Additional interview revealed the computer system is currently working..	W 440	The Administrator will in-service all Home Manager to ensure Fire Drills are conducted monthly and quarterly on each shift to include varied times and conditions. Home Manager will ensure Fire Drills are kept in a neat binder in the home. Monitoring will take place through monthly review of Fire Drills to be completed by the Administrator, In the future the Administrator will reivew Fire Drills monthly to ensure they are completed and at varied times and conditions.	4/1/22