DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	02/21/2023

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 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to update the Behavior Support Plan (BSP) annually for 1 of 3 audit clients (#1). The finding is: Review on 2/21/23 of client #1's record revealed a BSP dated 11/23/21 with a target date of 1/1/23. Additional review of client #1's record revealed no updated BSP since 11/23/21. Interview on 2/21/23 with the facility's behavior specialist confirmed client #1 did not have readily available updated BSP. The behavior specialist also confirmed client #1's BSP should have been updated following the target date of 1/1/23.	W 260		
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 interview, the facility failed to ensure the restrictive behavior techniques for 1 of 3 audit clients (#1) was reviewed and monitored by the human rights committee (HRC). The finding is: Review on 2/21/23 of client #1's Behavior Support Plan (BSP) dated 11/23/21 revealed target behaviors consisting of physical	W 262		

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

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 262	Continued From page 1 aggression, self-injurious behavior, property destruction, inappropriate sexual behaviors and severe disruption. Further review on 2/21/23 of client #1's BSP revealed no review or consent by the HRC. Interview on 2/21/23 with the facility's behavior specialist confirmed that based on the consent located in the record, client #1's BSP was not reviewed or consented to by the HRC.	W 262		
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 (#1). The finding is: Review on 2/21/23 of client #1's behavior support plan (BSP) dated 11/23/21 revealed target behaviors consisting of self injurious behavior, physical aggression, property destruction, inappropriate sexual behaviors and severe disruption. Further review of the BSP revealed medications consisting of Clonidine and Mellaril. Continued review of the BSP revealed guardian consent was last obtained on 9/25/21 and must be renewed annually from the date of guardian's signature. Interview on 2/21/23 with the qualified intellectual disabilities professional (QIDP) confirmed written	W 263		

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W 263	Continued From page 2 informed consent has not been obtained from the legal guardian since 9/25/21 and would no longer be valid. The QIDP confirmed that consent expires one year after guardian signature.	W 263		
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 interviews, the facility failed to ensure all staff were sufficiently trained in the proper wearing of masks. The finding is: Upon arrival to the home on 2/21/23 at 6:15am staff A invited surveyor into the home. Staff A was not wearing a mask. At no time between 6:15am and when staff A clocked out at 7:15am did the staff wear a mask. Interview on 2/21/23 with Qualified Intellectual Disabilities Professional (QIDP) revealed staff are required to wear a mask at all times. Interview on 2/21/23 with the nurse revealed the expectation is that all vaccinated staff wear a mask at all times and all unvaccinated staff will wear double masks.	W 340		
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:	W 440		

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W 440	Continued From page 3 The facility failed to assure fire drills were conducted quarterly for each shift of personnel as evidenced by interview and record verification. The finding is: Review on 2/21/23 of the facility's fire drill reports from revealed for the time period of February 2022 through February 2023, fire drills were not conducted at any time on third shift. Interview with the Qualified Intellectual Disabilities Professional (QIDP) revealed the home manager is responsible for the fire drill schedule. The QIDP confirmed fire drills should be conducted on all shifts quarterly.	W 440		