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 _____	12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY STREET HOME	1509 E 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
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004	E 004: The Facility Support Coordinator will be in-serviced on the requirements for the homes Emergency Plan. The Facility support coordinator will update the the EP to include the current residents, administrative contacts, and direct care staff contact information. The Program Director will monitor for compliance and will sign off on the updated manual. DHSR - Mental Health DEC 19 2023 Lic. & Cert. Section	2/3/24

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

Lindsay Platt | Program Director | 12/12/23

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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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and/or updated as needed. The finding is: Review on 12/4/23 of the facility's EP plan revealed it was last reviewed on 11/15/21. The plan noted it would be "reviewed and updated bi-annually." Additional review of the plan did not include any information regarding three clients who were recently admitted to the facility over the past 14 months. Further review of the EP plan did not include contact information for all direct care employees and administrative staff. Interview on 12/5/23 with the Clinical Director indicated the EP plan should have been updated by the Facility Support Coordinator as needed.	E 004		
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, document review and interviews, the facility failed to ensure all drugs are kept up to the point of administration. The findings are:	W 382	W 382: Program Director will meet with the Nursing department to in-service that medications should only be given if staff presents the medication lock box. The Nursing department will in-service direct care staff on policies and procedures related to transporting medications, as well as locking the medication room and cabinets. Program Director, Clinical Director, RSS, QP IID, and Nursing department will monitor for compliance.	2/3/24

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W 382	Continued From page 2 A. Upon arrival to the home on 12/4/23 at 3:32pm, Staff B exited the facility van carrying six pill cards in her hand. The staff entered the home and placed the cards in a medication cabinet and locked it. Immediate interview with Staff B revealed the pill cards belonged to client #3 and they had been retrieved from the nurse at the day program and transported to the home unsecured. Additional interview indicated they usually transport medications in a lock box. Review on 12/5/23 of the faciliy's Medication Storage policy (last revised 1/1/14) revealed, "All medication requiring transporting will be placed in a securely locked container." Interview on 12/5/23 with the facility's Registered Nurse (RN) and Licensed Practical Nurse (LPN) confirmed staff should only transport medications in a locked box. Additional interview indicated the home should have a designated lock box for securing medications during transport. B. During morning observations of medication administration in the home on 12/5/23 at 7:20a and 7:34a, Staff A left the door to the medication room and the medication cabinet unlocked as they went to retrieve a client. During additional observations at 7:28am, Staff A began assisting client #4 with dispensing his medications. During the medication pass, the staff left the medication area and entered the kitchen, leaving the door to the medication room and cabinets open and pill cards on the desk. Client #3 and the surveyor were also left in the medication area with the unsecured medications.	W 382		

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W 382	Continued From page 3 Interview on 12/5/23 with Staff A revealed she normally leaves the medication area unlocked as she goes to retrieve clients to take their medication. Additional interview indicated the door to the medication room and the medication cabinets should be kept locked. Review on 12/5/23 of the facility's Medication Storage policy (last revised 1/1/14) revealed, "The medication storage cabinet shall be locked at all times, when not under direct physical supervision of an RN or LPN." Interview on 12/5/23 with the RN and LPN confirmed the medication cabinets and the door to the medication room should be kept locked if the medication technician leaves the area while dispensing medications.	W 382		