STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G299	A. BUILDING _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLIDAY'S PLACE GROUP HOME	1108 QUAIL-MEADOW DRIVE FAYETTEVILLE, NC 28314

(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 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [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 at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop policy and procedures for sheltering in place in their emergency preparedness (EP) plan. This had the potential to affect all clients (#1, #2, #3 and #4). The finding is:	E 022		

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

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E 022	Continued From page 1 Record review on 7/15/24 of the EP revised on 6/1/24 revealed there was no policy for shelter in place, in the event of an emergency. Interview on 7/16/24 with the Director revealed she was unaware it was a requirement for their EP.	E 022		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.	E 039		

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E 039	Continued From page 2 (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years,	E 039		

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E 039	Continued From page 3	E 039		

opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a

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E 039	Continued From page 4 narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant	E 039		

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E 039	Continued From page 5 emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency	E 039		

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E 039	Continued From page 6 scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 7 (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.	E 039		

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E 039	Continued From page 8 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039		

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E 039	Continued From page 9 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct a tabletop exercise and mock	E 039		

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E 039	Continued From page 10 disaster drills to test their emergency preparedness (EP) plan. This had the potential to affect all of the clients (#1, #2, #3 and #4). The finding is: Review on 7/15/24 of the facility's EP revised on 6/1/24 revealed a Full-Scale exercise was completed on 12/5/23. There was no other evidence that a tabletop or mock drills (tornado, hurricane, power failure, etc..) were done with staff. Interview on 7/16/24 with the Director revealed she was unaware there was a requirement for a tabletop exercise. The Director acknowledged, staff have not been trained to do any mock drills, outside of fire drills.	E 039		
W 217	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 3 audit clients (#2) received an annual nutritional evaluation. The finding is: Observation on 7/15/24 at 5:15pm revealed client #2 received an unmeasured amount of regular ketchup that she added to baked fish. Client #2 also received 2 small cupcakes with icing for dessert. An additional observation at 6:40pm during medication administration, client #2 asked Staff A if she was going to record her blood sugar before receiving medications. Staff A responded to client #2 that she took her blood sugar earlier and recorded it.	W 217		

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W 217	Continued From page 11 Record review on 7/15/24 revealed the last nutritional evaluation completed on client #2 was on 11/17/17. The registered dietician recorded "[Client #2] Still struggles with sneaking food outside of scheduled meal times. Caregiver reports she crave high sugar food items. Reviewed the importance of consistent balanced intake. Follow-up in five years UNLESS drastic change in nutrition status noted. Limit sugar sweetened snacks to one per day, replacing other snacks with healthier alternatives. Limit processed snacks to one time per day. Healthy weight loss recommended to "lose 0.5-1 pound per week until target weight is reached. Estimated calorie needs 1400 calories." Record review on 7/15/24 revealed client #2 had a physical exam report on 11/14/23. The doctor ruled out the need to refer client #2 to see a nutritionist. Record review on 7/15/24 revealed a laboratory report on 4/17/24, a Hgb A1c test result was high at 7.4. The physician's response was to prescribe Metformin to treat client #2 for diabetes and to check client #2's blood sugar levels before meals at 7:00am and 5:00pm. The following data was recorded in July, 2024 for blood sugars: 7/8 at 420pm, BS 142 7/9 at 420pm, BS 171 7/10 at 430pm, BS 180 7/11 at 420pm, BS 166 7/12 at 420pm, BS 256 7/13 at 430pm, BS 222 7/14 at 420pm, BS 126 7/15 at 420pm, BS 243	W 217		

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W 217	Continued From page 12 Interview on 7/16/24 with the Director revealed they were not required to do an annual nutritional evaluation and the doctor did not find it necessary to request it. The Director revealed the Hgb A1c blood test was initiated because she had noticed client #2 was sleeping too much and wanted client #2 checked for diabetes. The Director's response to food received during last night's dinner, revealed that ketchup and the 2 mini cupcakes were okay for a diabetic to consume with them monitoring client #2's blood sugar. The Director acknowledged she did not know the ideal target range for client #2's blood sugar levels.	W 217		
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) 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 direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on observation and interview, the facility did not ensure med techs were proficiently trained in medication administration procedures. This affected 1 of 3 audit clients (#3). The finding is: Observation on 7/16/24 at 7:20am, Staff B removed the bin of medications for client #3 from the closet, without him being present; and proceeded to remove a Cetirizine pill from the packet and placed in a medicine cup. Staff B left the room to get client #3, while the surveyor and Director remained in the medication room. Staff B instructed client #3 to take his medication at	W 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G299	A. BUILDING _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLIDAY'S PLACE GROUP HOME	1108 QUAIL-MEADOW DRIVE FAYETTEVILLE, NC 28314

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W 342	Continued From page 13 7:21am. Client #3 ingested the medication and discarded the trash. Staff B was not observed to sign off on a medication administration record (MAR} that client #3 took his medication. Observation of Staff B at 8:02am, she returned to the medication room to get the MAR to document her med pass for client #3. Interview on 7/16/24 with Staff B revealed she was aware that she left client #3's medication on the counter when she left the room to get him. Staff B revealed she did not document in the MAR because the surveyor and director were in the room at the table where the MAR was kept and she intended to come back later to record. Interview on 7/16/24 with the Director who revealed she was a nurse, acknowledged Staff B should encourage the clients to participate in self-administration of their medications but it was okay to do it without the clients present. The Director also revealed staff should document medications in the MAR when given, instead of leaving the room and needing to come back to chart.	W 342		
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 observation and interview, the facility failed to ensure the Physician's Orders were administered as prescribed. This affected 1 of 3 audit clients (#2). The finding is: Observation on 7/15/24 at 5:15pm, revealed	W 368		

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	34G299	A. BUILDING _____ B. WING _____	07/16/2024

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W 368	Continued From page 14 client #2 ate a complete meal for dinner. An additional observation at 6:40pm, revealed client #2 was given 2 pills of Divalproex SOD 500mg by Staff A, without food. Review on 7/16/24 of client #2's Physician's Orders from 5/29/24 revealed client #2 should received Divalproex SOD with food at 7:00pm. Interview on 7/16/24 with the Director revealed she was a nurse and did not have a medication administration policy available for review. The Director revealed that staff were trained to use crackers or pudding to offer with medications that need to be taken with food.	W 368		
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 medications were secured in a locked cabinet, when not passing medications. The finding is: Observations in the home on 7/16/24 from 7:20am to 8:02am, Staff B did not use a key to go in and out of the medication closet, to remove medications, even when leaving the room. An additional observation at 7:25am revealed a signed taped to the wall in the medication room that read "Medication keys are to be kept by the lead person and passed to oncoming lead person." Interview on 7/16/24 with Staff B, revealed she	W 382		

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	34G299	A. BUILDING _____ B. WING _____	07/16/2024

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W 382	Continued From page 15 confirmed the medication closet was left unlocked when she left the room to get the next client. Interview on 7/16/24 with the Director and the Habilitation Coordinator, revealed staff should keep the medication closet locked.	W 382		
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 record review and interview, the facility failed to ensure fire drills were conducted on every shift, each quarter. The finding is: Review on 7/15/24 of fire drills conducted revealed the following details: A. There was no drill performed on 2nd shift during the 1st quarter (January-March) of 2024. B. There were no drills performed on 3rd shift during the 3rd quarter (July-September) 2023 and during the 2nd quarter (April-June) 2024. Interview on 7/16/24 with the Director revealed she did not realize they had missed three fire drills.	W 440		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, record review and	W 460		

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W 460	Continued From page 16 interview, the facility failed to ensure 1 of 3 audit clients (#1) received the correct modifications for the prescribed diet. The finding is: Observation on 7/15/24 at 1:00pm, the home manager supervised the clients eating lunch. Client #1 was observed holding a large piece of sandwich (approximately 2"x2"), which she consumed along with a banana that was cut in half. Client #1 was observed ingesting the food, without incident. Review on 7/15/24 of client #1's individual program plan (IPP) from 11/1/23 revealed a dietary order of 1500 calories, regular diet, with no seconds, in bite-sized pieces. Interview on 7/16/24 with the home manager revealed she thought cutting the sandwich into 6 squares was considered bite-sized pieces. Interview on 7/16/24 with the Director confirmed client #1's food should be prepared in bite-sized pieces.	W 460		