

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026
NAME OF PROVIDER OR SUPPLIER HOLLOWAY STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4795 STANLEY ROAD , DURHAM, North Carolina, 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
W0186	<p>DIRECT CARE STAFF</p> <p>CFR(s): 483.430(d)(1-2)</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interviews, the facility failed to maintain an appropriate level of staff supervision to provide needed care and services for all clients in the home (#1, #2, #3, #4, #5, #6). The finding is:</p> <p>During observations in the home on 3/24/26, staff A is the only staff member available to transport the clients to the day program. No other staff available to assist them in case of emergency.</p> <p>Review on 3/23/26 of client #1 Individual Program Plan (IPP) dated 9/24/25 revealed client #1 is to be always monitored when in the community due to possible aggression.</p> <p>Review on 3/23/26 of client #6 Individual Program Plan (IPP) dated 2/18/26 revealed in the community, it's important that staff to remain close to him, monitoring and supervision should be provided to ensure safety.</p> <p>Review on 3/23/26 of staff list of the home, revealed staff A is the only staff assigned to 1st shift.</p> <p>Interview with a qualified intellectual disabilities professional (QIDP) revealed that only one staff member is currently transporting the clients at this time.</p>	W0186		
W0249	<p>PROGRAM IMPLEMENTATION</p> <p>CFR(s): 483.440(d)(1)</p>	W0249		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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W0249	<p>Continued from page 1</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record review and interview, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services for 2 of 3 audit clients (#5 and #6). The findings are:</p> <p>A. During observations in the home on 3/23/26 from 3:15pm to 6:00pm, client #5 only came out of his room to eat dinner, place his dishes on the counter and returned back to his room.</p> <p>Further observations in the home on 3/24/26 from 6:30am to 8:00am, client #5 only came out of his to eat breakfast, place his dishes on the counter and returned back to his room.</p> <p>Interview with staff C on 3/23/26 revealed when client #5 is home, he stays in his room all night and only interacts during mealtimes.</p> <p>Interview with qualified intellectual disabilities professional (QIDP) on 3/24/26 revealed staff should encourage client #5 to participate in activities and socialization.</p> <p>B. Observations of meals in the home on 3/23/26 and 3/24/26, client #6 was served dinner and breakfast sitting at the table with his peers. Client #6 was given a serving of shrimp, carrots and green beans at dinner on 3/23/26 at one time. On 3/24/26, client #6 was given oatmeal, toast and sausage at one time.</p> <p>Record review on 3/23/26 of client #6's behavior support plan (BSP) dated 1/1/25 revealed a mealtime protocol that client #6 should sit at a sufficient distance from peers during meals, meals should be divided into quarters and given to client #6 one portion at a time.</p> <p>Interview on 3/24/26 with the QIDP revealed she was not sure if staff had been trained on the mealtime protocol for client #6. The QIDP confirmed the guidelines should be followed if they are in the BSP.</p>	W0249		
W0252	PROGRAM DOCUMENTATION	W0252		

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W0252	<p>Continued from page 2</p> <p>CFR(s): 483.440(e)(1)</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure data relative to accomplishment of the criteria specified in clients individual program plan (IPP) were documented in measurable terms. This affected 2 of 3 audit clients. The findings are:</p> <p>A. Review on 3/23/26 of client #5's Individual Program Plan (IPP) dated 10/13/25 revealed formal training programs as follows: Staff will assist client #5 with monitoring the meat while it cooks and will inform him when it is fully done. Training will occur twice per week during the dinner preparation period. There were no other goals to review.</p> <p>Review on 3/24/26 of client #5's training documentation revealed for the month of February 2026 documentation had only been collected twice out of the entire month.</p> <p>B. Review on 3/23/26 of client #6's Individual Program Plan (IPP) dated 2/18/26 revealed formal training programs as follows: privacy, with data to be collected twice daily; wash lower body with data to be collected twice daily and toothbrushing with data to be collected 5 times per week.</p> <p>Review on 3/24/26 of client #6's training documentation revealed for the month of February 2026 documentation had only been collected once for privacy goal, no data collected for washing lower body and 5 times for toothbrushing goal. Review of March 2025 revealed documentation had been collected 8 times for privacy and 5 times for washing lower body.</p> <p>Interview with habilitation specialist on 3/24/26 confirmed that documentation was not being collected as the goals were written.</p>	W0252		
W0260	<p>PROGRAM MONITORING & CHANGE</p> <p>CFR(s): 483.440(f)(2)</p> <p>At least annually, the individual program plan must be revised, as appropriate, repeating the process set</p>	W0260		

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W0260	Continued from page 3 forth in paragraph (c) of this section. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Program Plan (IPP) was updated annually for 1 of 3 audit clients (#6). The finding is: Record review on 3/23/26 for client #6 revealed a behavior support plan (BSP) with an implementation date of 1/1/25 and a target date of 1/1/26. No current BSP could be located. Interview on 3/24/26 with the qualified intellectual disabilities professional (QIDP) confirmed no current BSP could be located for client #6.	W0260		
W0262	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 (#6) was reviewed and monitored by the human rights committee (HRC). The finding is: Review on 3/23/26 of client #6's behavior support plan (BSP) dated 1/1/25 revealed target behaviors for hitting/aggression, overeating and damaging property. The BSP listed the use of the medications Cogentin, Naltrexone and Abilify. Further review on 3/24/26 of client #6's physician's orders dated 2/10/26 revealed an order for Naltrexone, Abilify and Fluvoxamine for behaviors. No HRC consent for Fluvoxamine could be located. Interview on 3/24/26 with the qualified intellectual disabilities professional revealed no HRC consent for Fluvoxamine had been obtained.	W0262		
W0341	NURSING SERVICES CFR(s): 483.460(c)(5)(ii)	W0341		

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W0341	Continued from page 4 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 control of communicable diseases and infections, including the instruction of other personnel imethods of infection control. This STANDARD is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained on appropriate health and hygiene methods regarding glove use. The finding is: During observations in the home on 3/24/26 at 7:28am, staff A used gloves to do various task such as clean dishes, wipe his nose, and move food around. Staff A was also observed feeding client #1 with the same gloves on. Interview with nurse on 3/24/26 revealed staff should change gloves between uses.	W0341		
W0368	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, record review and interview, the facility failed to ensure that all drugs are administered in compliance with physician's orders. This effected 1 of 3 audit clients (#1). The finding is: During observations of the medication administration pass on 3/23/26 at 7:20am, staff E was observed administering Propranolol 30mg to client #1. No vital signs were obtained prior to giving the medication. Review on 3/24/26 of client #1's physician's orders dated 2/10/26 revealed an order for Propranolol 30mg by mouth every day, hold for blood pressure less than 90/60. Interview on 3/24/26 with the facility nurse revealed client #1's blood pressure should always be taken prior to the administration of Propranolol.	W0368		
W0460	FOOD AND NUTRITION SERVICES	W0460		

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W0460	<p>Continued from page 5</p> <p>CFR(s): 483.480(a)(1)</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure each client received modified and specially prescribed diets for 2 of 3 audit clients (#1 and #6). The findings are:</p> <p>A. Observations of dinner on 3/23/26 at approximately 5:09pm, client #1 was observed eating dinner. Client #1 was served oven grilled shrimp, string beans and carrots. Client #1 food was served whole.</p> <p>Further observations on 3/24/26 at approximately 7:20am, client #1 was observed eating breakfast that consisted of sausage, oatmeal and toast. Staff A cut client #6's sausage up into approximately 1-inch pieces and the toast remained whole.</p> <p>Record review on 3/23/26 of client #1's nutritional evaluation dated 7/4/25 revealed a recommendation for a heart healthy, 1/2-inch consistency diet.</p> <p>B. Observations of dinner on 3/23/26 at approximately 5:09pm, client #6 was observed eating dinner. Client #6 was served oven grilled shrimp, string beans, carrots and whole wheat bread.</p> <p>Further observations on 3/24/26 at approximately 7:20am, client #6 was observed eating breakfast that consisted of sausage, oatmeal and toast. Staff A cut client #6's sausage up into approximately 1-inch pieces and the toast remained whole.</p> <p>Record review on 3/23/26 of client #6's nutritional evaluation dated 12/3/25 revealed a recommendation for a heart healthy, 1/2-inch consistency diet.</p> <p>Interview on 3/24/26 with the qualified intellectual disabilities professional (QIDP) confirmed client #1 and client #6 should have received heart healthy, 1/2-inch consistency diet. The QIDP confirmed client #1 and client #6 should not have received any foods that exceeded 1/2 inch.</p>	W0460		
W0473	<p>MEAL SERVICES</p> <p>CFR(s): 483.480(b)(2)(ii)</p>	W0473		

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W0473	<p>Continued from page 6 Food must be served at appropriate temperature.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interviews, the facility failed to ensure food was served at the appropriate temperature. This potentially affected clients 6 of 6 clients. The finding is:</p> <p>During dinner observations in the home on 3/23/26 at 5:09pm, staff D put the clients food on the counter and covered it with a paper towel at 4:45pm. At 5:09pm staff served food to the clients.</p> <p>Interview with qualified intellectual disabilities professional (QIDP) on 3/24/26 revealed food should have been served within 15 minutes.</p>	W0473		