STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G298	A. BUILDING _____ B. WING _____	01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET	206 LUKE STREET EDENTON, NC 27932

(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 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure a sanitary environment was provided to avoid transmission of infections and prevent possible cross-contamination. This potentially affected all clients residing in the home. The finding is: Precautions were not taken to promote client/staff health/safety and prevent possible cross-contamination. During observations in the home on 1/7/19 at approximately 5:39pm, client #5 walked to his room accompanied by the staff who was assigned to him, while staff was wearing gloves. At 5:43pm the staff walked out of the clients room while still wearing gloves. The client continued moving around the house. The staff touched kitchen counter, the tablet, the files among others. At 5:51pm the staff helped the client to prepare a soft taco while still wearing gloves. The client left the table at 6:13pm. At no time did the staff change the gloves. During an interview on 1/7/19, the staff revealed gloves should be worn while there is potention of contamination and staff should have washed their hands before proceeding to another activity. During an interview on 1/7/19, the qualified intellectual disabilities professional (QIDP) revealed the staff should have removed the	W 454		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 454	Continued From page 1 gloves after leaving the clients room and washed their hands before handling food.	W 454		