		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI	0938-0391 E SURVEY PLETED
		34G240	B. WING			02/	17/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
DICKEN	S DRIVE HOME				13 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 037	CFR(s): 483.475(d) *[For RNCHIs at §4 Hospitals at §482.1 at §484.102, "Organ OPOs at §486.360, Training program. T following: (i) Initial training policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) Provide eme at least every 2 yea (iii) Maintain do preparedness traini (iv) Demonstrate emergency procedu (v) If the emerg and procedures are [facility] must condu policies and proced *[For Hospices at § hospice must do all (i) Initial training policies and proced hospice employees services under arra expected roles. (ii) Demonstrate emergency procedu (iii) Provide em at least every 2 yea (iv) Periodically emergency prepare employees (includir	 a) (1) b) (3.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs nizations" under §485.727, RHC/FQHCs at §491.12:] (1) c) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	EC	037			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 02/18/2021

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.

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
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		34G240	B. WING	i		02 / ⁻	17/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
DICKENS	S DRIVE HOME				113 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 037	procedures necessa others. (v) Maintain doo preparedness traini (vi) If the emerg and procedures are hospice must condu policies and proced *[For PRTFs at §44 program. The PRTF (i) Initial training policies and proced staff, individuals pro arrangement, and v expected roles. (ii) After initial tr preparedness traini (iii) Demonstrat emergency procedu (iv) Maintain do preparedness traini (v) If the emerg and procedures are PRTF must conduc policies and proced *[For LTC Facilities Program. The LTC f following: (i) Initial training policies and proced staff, individuals pro arrangement, and v expected role. (ii) Provide eme at least annually.	ary to protect patients and cumentation of all emergency ing. gency preparedness policies e significantly updated, the uct training on the updated lures. 41.184(d):] (1) Training F must do all of the following: g in emergency preparedness lures to all new and existing oviding services under volunteers, consistent with their raining, provide emergency ing every 2 years. te staff knowledge of ures. ocumentation of all emergency ing. jency preparedness policies e significantly updated, the et training on the updated lures. at §483.73(d):] (1) Training facility must do all of the g in emergency preparedness lures to all new and existing		037			

Facility ID: 921760

If continuation sheet Page 2 of 21

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G240	B. WING			02/ [,]	17/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
DICKENS	S DRIVE HOME				113 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	preparedness traini (iv) Demonstrate emergency procedu *[For CORFs at §48 CORF must do all of (i) Provide initia preparedness polici and existing staff, ir services under arra consistent with their (ii) Provide emer at least every 2 yea (iii) Maintain do (iv) Demonstrate emergency procedu be oriented and ass responsibilities emergency plan wit workday. The training instruction in the loo systems and signals (v) If the emer and procedures are CORF must conduct policies and proced *[For CAHs at §485 The CAH must do a (i) Initial training policies and proced reporting and exting and where necessa personnel, and gue cooperation with authorities, to all ne individuals providing	ing. te staff knowledge of ures. 85.68(d):](1) Training. The of the following: al training in emergency ies and procedures to all new ndividuals providing ingement, and volunteers, r expected roles. ergency preparedness training irs. coumentation of the training. te staff knowledge of ures. All new personnel must signed specific regarding the CORF's thin 2 weeks of their first ng program must include cation and use of alarm s and firefighting equipment. rgency preparedness policies e significantly updated, the ct training on the updated lures. 5.625(d):] (1) Training program.	E	037			

Facility ID: 921760

If continuation sheet Page 3 of 21

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		34G240	B. WING			02/	17/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
DICKEN	S DRIVE HOME				13 DICKENS DRIVE CALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	at least every 2 yea (iii) Maintain do (iv) Demonstrate emergency procedu (v) If the emer and procedures are CAH must conduct policies and procedu *[For CMHCs at §4 CMHC must provid preparedness polic and existing staff, in under arrangement with their expected documentation of th demonstrate staff k procedures. There emergency prepare years. This STANDARD is Based on document facility failed to ens adequately trained prepardness (EP) p Review on 2/16/21 (2020) did not inclu training of staff. During an interview manager confirmed	ergency preparedness training ars. boumentation of the training. te staff knowledge of ures. rgency preparedness policies e significantly updated, the training on the updated dures. 85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new ndividuals providing services t, and volunteers, consistent roles, and maintain ne training. The CMHC must showledge of emergency after, the CMHC must provide edness training at least every 2 s not met as evidenced by: nt review and interviews, the ure direct care staff were on the facility's emergency olan. The finding is: of the facility's EP manual de any information regarding	EC	037			

If continuation sheet Page 4 of 21

		AND HUMAN SERVICES				FORM	: 02/18/2021 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		34G240	B. WING	i		02/	17/2021
NAME OF F	PROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
DICKEN	S DRIVE HOME				113 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	*[For RNCHI at §40 HHAs at §484.102, "Organizations" und §485.920, RHC/FQ Facilities at §494.62 (2) Testing. The [fact to test the emergen must do all of the for (i) Participate in community-based et (A) When a not accessible, com- exercise every 2 (B) If the [fa natural or man-mact activation of the em- is exempt from eng community-based of functional et the actual event. (ii) Conduct an every 2 years, opport functional exercise this section is condi- not limited to the for (A) A secor community-based of functional exercise; (B) A mock (C) A tablet is led by a facilitator discussion using a clinically-releva set of problem state prepared questions emergency plan.	 3.748, ASCs at §416.54, CORFs at §485.68, OPO, der §485.727, CMHC at HC at §491.12, ESRD cility] must conduct exercises hey plan annually. The [facility] blowing: a full-scale exercise that is every 2 years; or a community-based exercise is duct a facility-based functional years; or acility] experiences an actual de emergency that requires hergency plan, the [facility] aging in its next required or individual, facility-based exercise following the onset of additional exercise at least beite the year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: ad full-scale exercise that is or individual, facility-based or disaster drill; or top exercise or workshop that r and includes a group narrated, int emergency scenario, and a ements, directed messages, or 		039	9		

		AND HUMAN SERVICES			FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		34G240	B. WING		02/	17/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DICKENS	S DRIVE HOME			113 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 039	maintain document exercises, and eme revise the [facility's] *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate i community based e (A) When a not accessible, con based functional ex (B) If the ho or man-made emer of the emergency p exempt from engage scale community-based facility-based the facility-based the functional exercise this section is cond not limited to the fo (A) A seco community-based of exercise; or (B) A moch (C) A table is led by a facilitator discussion using a clinically-releva	ation of all drills, tabletop ergency events, and emergency plan, as needed. 18.113(d):] bices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: n a full-scale exercise that is every 2 years; or a community based exercise is duct an individual facility tercise every 2 years; or ospice experiences a natural gency that requires activation lan, the hospital is ging in its next required full ased exercise or individual functional exercise following ergency event. additional exercise every 2 year the full-scale or under paragraph (d) (2)(i) of ucted, that may include, but is llowing: nd full-scale exercise that is or a facility based functional c disaster drill; or top exercise or workshop that r and includes a group narrated, nt emergency scenario, and a ements, directed messages, or	E 039			

Facility ID: 921760

If continuation sheet Page 6 of 21

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G240	B. WING			02 / ⁻	17/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICKENS	S DRIVE HOME				13 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	 (3) Testing for hosp care directly. The hespice directly. The hespice (i) Participate in that is community-beside (A) When a not accessible, comfacility-based function (B) If the hespice or man-made emer of the emergency pexempt from engag full-scale communit functional of the emergency e (ii) Conduct an that may include, be following: (A) A seconomunity-based or exercise; or (B) A moch (C) A table by a facilitator that i using a narrated, emergency plan. (iii) Analyze the maintain document exercises, and emergency community-based for the emergency community compared the hospice's emergency plan. 	ices that provide inpatient hospice must conduct e emergency plan twice per must do the following: n an annual full-scale exercise based; or a community-based exercise is duct an annual individual onal exercise; or ospice experiences a natural gency that requires activation lan, the hospice is jing in its next required cy based or facility-based exercise following the onset vent. additional annual exercise ut is not limited to the nd full-scale exercise that is or a facility based functional c disaster drill; or top exercise or workshop led ncludes a group discussion clinically-relevant o, and a set of problem d messages, or prepared signed to challenge an e hospice's response to and ation of all drills, tabletop ergency events and revise gency plan, as needed. 1.184(d), Hospitals at	EC	039			

If continuation sheet Page 7 of 21

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>·</i>			(X3) DATE	E SURVEY PLETED
		34G240	B. WING	i		02/1	17/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DICKENS	B DRIVE HOME				113 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	twice per year. The do the following: (i) Participate in that is community-b (A) When a not accessible, com- facility-based function (B) If the [P experiences an acture emergency that req emergency plan, the engaging in its next based or functional exercises emergency event. (ii) Conduct an and that may includ following: (A) A second functional exercise; (B) A mock (C) A tablet is led by a facilitator discussion, using a clinically-releva set of problem state prepared questions emergency plan. (iii) Analyze the maintain documents exercises, and eme the [facility's] emergency (2) The [LTC facility	to test the emergency plan e [PRTF, Hospital, CAH] must in an annual full-scale exercise based; or a community-based exercise is duct an annual individual, onal exercise; or PRTF, Hospital, CAH] ual natural or man-made pures activation of the e [facility] is exempt from the e [facility] is exempt from the e [facility] is exempt from the onset of the [additional] annual exercise or le, but is not limited to the following the onset of the [additional] annual exercise or le, but is not limited to the the full-scale exercise that is prindividual, a facility-based or disaster drill; or top exercise or workshop that r and includes a group narrated, nt emergency scenario, and a ements, directed messages, or designed to challenge an f[facility's] response to and ation of all drills, tabletop ergency events and revise gency plan, as needed.	EC	039			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 02/18/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		34G240	B. WING			02/	17/2021
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
DICKEN	S DRIVE HOME				113 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	including unannoun emergency procedu ICF/IID] must do the (i) Participate in that is community-b (A) When a not accessible, com- facility-based functi- (B) If the [L] an actual natural or requires activation of the LTC facility is ex- required a full-scale individual, facili following the onset (ii) Conduct an that may include, but following: (A) A seco community-based of functional exercise; (B) A mock (C) A table is led by a facilitator using a narrated, emergency scenario statements, directed questions des emergency plan. (iii) Analyze the response to and ma drills, tabletop exerce events, and revise t emergency plan, as *[For ICF/IIDs at §4 (2) Testing. The ICF	aced staff drills using the ures. The [LTC facility, e following: n an annual full-scale exercise based; or a community-based exercise is duct an annual individual, onal exercise. TC facility] facility experiences man-made emergency that of the emergency plan, kempt from engaging its next e community-based or ty-based functional exercise of the emergency event. additional annual exercise of the emergency event. additional annual exercise ut is not limited to the nd full-scale exercise that is or an individual, facility based or c disaster drill; or top exercise or workshop that r includes a group discussion, clinically-relevant o, and a set of problem d messages, or prepared signed to challenge an e [LTC facility] facility's aintain documentation of all cises, and emergency the [LTC facility] facility's a needed.	E)39			

If continuation sheet Page 9 of 21

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		34G240	B. WING	i		02/1	17/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DICKEN	S DRIVE HOME				113 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	The ICF/IID must d (i) Participate in that is community-b (A) When a not accessible, com facility-based functi (B) If the IC natural or man-mac activation of the em is exempt from eng full-scale communit based functiona of the emergency e (ii) Conduct an may include, but is (A) A secor community-based of functional exercise; (B) A mock (C) A tablet is led by a facilitator discussion, using a clinically-releva set of problem state prepared questions emergency plan. (iii) Analyze the maintain document exercises, and eme the ICF/IID's emergent (d)(2) Testing. The to test the emergent following: (i) Conduct a participation (ii) Conduct a participation following: (i) Conduct a participation (ii) Conduct a participation (iii) Conduct a participation (iiiii) Conduct a participation (iiii) Conduct a participation (iiii) Conduct (iiii) Conduct (iii) Conduct (iiii) Conduct (iiii) Conduct (iii) Conduct (iiii) Conduct (iiiii	o the following: a an annual full-scale exercise based; or a community-based exercise is duct an annual individual, onal exercise; or. CF/IID experiences an actual de emergency that requires hergency plan, the ICF/IID aging in its next required ty-based or individual, facility- al exercise following the onset vent. additional annual exercise that not limited to the following: the full-scale exercise that is or an individual, facility-based or disaster drill; or top exercise or workshop that r and includes a group narrated, nt emergency scenario, and a ements, directed messages, or designed to challenge an PICF/IID's response to and ation of all drills, tabletop ergency events, and revise gency plan, as needed. 6.360] OPO must conduct exercises for plan. The OPO must do the aper-based, tabletop exercise at annually. A tabletop exercise		039			

If continuation sheet Page 10 of 21

		AND HUMAN SERVICES			FORM	02/18/2021 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G240	B. WING	 	02/	17/2021	
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-		
DICKENS	S DRIVE HOME			13 DICKENS DRIVE ALEIGH, NC 27610			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
E 039 W 130	emergency scenaris statements, dira questions designed plan. If the OPO ex or man-made emer of the emergency p engaging in its next following the onset (ii) Analyze the maintain document and emergency eve and OPO's] emerge This STANDARD is Based on document facility failed to ension tabletop exercise Preparedness (EP) potentially affected finding is: Review on 2/17/21 January 2021, did r community-based of During an interview manager revealed to tabletop exercise for PROTECTION OF CFR(s): 483.420(a) The facility must em Therefore, the facility treatment and care	narrated, clinically relevant o, and a set of problem ected messages, or prepared to challenge an emergency periences an actual natural gency that requires activation lan, the OPO is exempt from a required testing exercise of the emergency event. OPO's response to and ation of all tabletop exercises, ents, and revise the [RNHCI's ency plan, as needed. s not met as evidenced by: nt review and interviews, the ure facility/community-based es to test their Emergency plan were conducted. This all clients in the home. The of the facility's EP plan dated not include a full-scale or tabletop exercise for 2020. con 2/17/21, the program the facility did not perform a or 2020. CLIENTS RIGHTS (7) asure the rights of all clients. ity must ensure privacy during of personal needs.	E 0				
		s not met as evidenced by: tions, record review and					

Facility ID: 921760

If continuation sheet Page 11 of 21

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G240	B. WING			02/ [,]	17/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICKEN	B DRIVE HOME				13 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 130	1 of 6 audit clients (finding is: During morning obs 2/17/21 at 5:40am, Further observation have any clothes or revealed client #3 th hall. At 5:42am, clie hall towards his bed just his underwear. clients were up, dre home. At no time v on his bathrobe. During an immediat "[Client #4] sleep in revealed client #4 n his bathrobe on. During review on 2/ program plan (IPP) "NEEDS: Selects of situations." During an interview manager revealed of to put on his bathrob bedroom in the more STAFF TRAINING CFR(s): 483.430(e)	thy failed to ensure privacy for (#4) residing in the home. The servations in the home on client #4 exited the bathroom. Is revealed client #4 did not h. Additional observations urning to the right down the ent #4 came back down the droom and he was wearing During this time four other essed and walking though the vas client #4 prompted to put the interview Staff A stated, the nude." Further interview leeds to be reminded to put (17/21 of client #4's individual dated 3/10/20 stated, clothing for appropriate on 2/17/21, the program client #4 should be reminded be before he exits his ming. PROGRAM (1) ovide each employee with g training that enables the m his or her duties effectively,	W -				

Facility ID: 921760

If continuation sheet Page 12 of 21

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G240	B. WING			02/ [,]	17/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICKENS	S DRIVE HOME				13 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 189	Continued From pa	ige 12	W 1	189			
	Based on observat interviews, the facil	s not met as evidenced by: tions, record review and ity failed to ensure staff were n assisting clients with s. The finding is:					
	2/16/21 at 9:10am, from a hamper in th placed them into th 9:11am, client #2 w	observations in the home on client #2 removed dirty linen he laundry room area and e washing machine. At ras observed folding clean away. At no time was client #2 his hands.					
	2/16/21 at 9:53am, removed a glass fro refrigerator, took a	observations in the home on client #3 went into the kitchen om the cabinet, opened the container of milk out and ass. At no time was client #3 his hands.					
	inservice dated 3/23 inserviced to accom	of facility hand washing 3/20 revealed staff had been npany clients into the e they wash their hands.					
	guidelines (2020) si the bathroom (Ensu route). 2. Assist cl 3. Assist client with client with applying antibacterial soap. 6. Client should rul in between fingers,	of the facility's hand washing tated, "1. Accompany client to ure nothing is touched in lient with turning on the water. n wetting hands. 4. Assist appropriate amount of 5. Start timer for 20 seconds. b inside and outside of hands, and fingernails thoroughly."					
		ts #2 and #3 hands should					

Facility ID: 921760

If continuation sheet Page 13 of 21

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G240	B. WING			02/1	17/2021
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICKENS	S DRIVE HOME				13 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 189	• • • • • • • • • • • • • • • • • • •	-	W 1	89			
W 213	have been washed. INDIVIDUAL PROG CFR(s): 483.440(c)	GRAM PLAN	W 2	213			
		e functional assessment must specific developmental					
	Based on record re failed to ensure 6 or	s not met as evidenced by: eview and interview, the facility of 6 audit clients (#1, #2, #3, ptive behavior inventory (ABI) The findings are:					
	program plan (IPP) admitted to the faci	/21 of client #1's individual dated 2/4/21 revealed he was lity on 2/1/20. Further review does not have a ABI.					
	7/7/20 revealed he	/21 of client #2's IPP dated was admitted to the facility on riew revealed client #2 does					
	4/11/20 revealed he	/21 of client #3's IPP dated e was admitted to the facility r review revealed client #3 81.					
	3/10/20 revealed he	/21 of client #4's IPP dated e was admitted to the facility review revealed client #4 does					
	6/9/20 revealed he	/21 of client #5's IPP dated was admitted to the facility on eview revealed client #5 does					

Facility ID: 921760

If continuation sheet Page 14 of 21

		AND HUMAN SERVICES			FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		34G240	B. WING		02/1	17/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DICKENS	S DRIVE HOME			13 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 213	Continued From pa not have a ABI.	ige 14	W 213			
	8/4/20 revealed he	/21 of client #6's IPP dated was admitted to the facility on eview revealed client #6 does				
W 252	manager revealed t for the clients was i	MENTATION	W 252			
	specified in client in	complishment of the criteria ndividual program plan documented in measurable				
	Based on docume the facility failed to	s not met as evidenced by: ntation review and interviews, ensure data was documented cted 1 of 6 audit clients (#1).				
	revealed missing da 1/21 thru 1/24 and 2 revealed client #4 h plan (BIP) dated 1/2 aggression, head o vocalizations. Clien Frequency of all tan documented on the Review of the beha	/21 of client #4's behavior data ata for the following dates: 2/3 thru 2/9/21. Further review has a behavior intervention 21 with the target behaviors of or chest hitting and loud ht #4's BIP stated, "1. "get behaviors should be behavior data sheets." avior data sheets revealed ocument if client #4 does not is for the day.				

If continuation sheet Page 15 of 21

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G240	B. WING			02/ [,]	17/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
DICKENS	S DRIVE HOME				13 DICKENS DRIVE ALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 252	Continued From pa	ge 15	W 2	252			
	intellectual disabiliti	on 2/16/21, the qualified es professional (QIDP) data for client #4 should be					
		ions in the home on 2/16 and fingernails had grown over the					
	hygiene/body check for the following dat 11/11; 11/18; 11/25; 12/23; 12/30; 1/6; 1 of the weekly hygien	of client #4's weekly s sheet revealed missing data tes: 10/14; 10/21; 10/28; 11/4; ; 12/2; 12/2; 12/9; 12/16; /13; 1/29; 2/3; and 2/11. Part ne/body check sheet had a "Do fingernailsneed					
W 255	manager revealed t fingernails should b Wednesday of the	on 2/17/21, the home the data for cutting client #4's be documented every week on second shift. FORING & CHANGE (1)(i)	W 2	255			
	least by the qualifie professional and re- but not limited to sit successfully comple- identified in the indi This STANDARD is Based on record re- failed to ensure 5 or #6) individual progra	ram plan must be reviewed at d intellectual disability vised as necessary, including, tuations in which the client has eted an objective or objectives vidual program plan. s not met as evidenced by: eview and interview, the facility f 6 clients (#1, #2, #3, #5 and am plan (IPP) were reviewed eeded when the target date ndings are:					

If continuation sheet Page 16 of 21

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G240	B. WING			02 / [,]	17/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
DICKENS	S DRIVE HOME				13 DICKENS DRIVE ALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 255	Continued From pa	ige 16	W 2	255			
W 255	 A. Review on 2/16/ brush his teeth and target date of 12/20 goals have not been B. Review on 2/16/ complete a purchas target date of 12/20 goals have not been C. Review on 2/16/ complete a purchas bathroom doors wh of 12/20. Further re- not been reviewed of D. Review on 2/16/ teeth daily and com- target date of 12/20 goals have not been E. Review on 2/16/ the bathroom door and complete a pur 12/20. Further revi- not been reviewed of During an interview intellectual disabiliti- revealed all the goal and #6 have steps 	 /21 of client #1's goals to /21 of client #1's goals to /21 of client review revealed the n reviewed or revised. /21 of client #2's goals to /21 of client #2's goals to /21 of client #3's goals to /21 of client #5's goals to floss /21 of client #6's goals to close 	W 2	255			
	moving on to the nervealed all the step same time. The QI had written the goa unsure why they we	est one. Further interview ps have been running at the IDP revealed the former QIDP Is that way and she was ere written that way. Additional the goals have a target date of					

Facility ID: 921760

If continuation sheet Page 17 of 21

					0938-039	
ND PLAN OF CODDECTION				(X3) DATE SURVEY COMPLETED		
	34G240	B. WING		02/	17/2021	
ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
DRIVE HOME						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETIO DATE	
	-	W 255				
revised. INFECTION CONT	ROL	W 455				
There must be an a prevention, control,	active program for the , and investigation of infection					
provided to avoid tr infections and prev cross-contaminatio the clients residing A. During morning 9:03am, the survey front door and was (HM). The HM stat needed to be take The HM then place directly on the foref her skin. Observat sanitizer and a spra table next to the fro During an immedia digital thermometer	ransmission of possible ent possible in. This potentially affected all in the home. The findings are: observations on 2/16/21 at vor entered the home and the greeted by the home manager ted the surveyors' temperature prior to entering the home. In the digital thermometer head of the surveyor touching ions revealed a bottle of hand ay can of Lysol sitting on the ont door.					
	ROVIDER OR SUPPLIER DRIVE HOME SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa 12/20 and they need revised. INFECTION CONT CFR(s): 483.470(I) There must be an a prevention, control, and communicable This STANDARD is Based on observation failed to ensure a s provided to avoid tr infections and preventions the clients residing A. During morning 9:03am, the survey front door and was (HM). The HM state needed to be take The HM then placed directly on the fored her skin. Observation table next to the from During an immedia	F CORRECTION IDENTIFICATION NUMBER: 34G240 34G240 ROVIDER OR SUPPLIER DRIVE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 12/20 and they need to be reviewed and or	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 34G240 B. WING	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 34G240 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DRIVE HOME STREET ADDRESS, CITY, STATE, ZIP CODE 13 DICKENS DRIVE RALEIGH, NC 27610 TAG Continued From page 17 PREFIX 12/20 and they need to be reviewed and or revised. PREFIX 12/20 and they need to be reviewed and or revised. W 255 INFECTION CONTROL CFR(s): 483.470(I)(1) W 455 W 455 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infections and prevent possible cross-contamination. This potentially affected all the clients residing in the home. The findings are: A. During morning observations on 2/16/21 at 9:03am, the surveyor entered the home and the foront door and was greeded by the home manager (HM). The HM stated the surveyors' temperature needed to be take prior to entering the home. The HM then placed the digital thermometer directly on the forehead of the surveyor touching her skin. Observations revealed a bottle of hand sanitizer and a spray can of Lysol sitting on the table next to the front door. Image: A strate of the surveyor touching her skin. Observations revealed a bottle of hand sanitizer and a spray can of Lysol sitting on the table next to the front door.	CORRECTION IDENTIFICATION NUMBER: A BUILDING COM 346240 B. WING 02/ ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 13 DICKENS DRIVE RALEIGH, NC 27610 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE REQULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX CACOSE-REFERENCE OT ON SHOULD BE Continued From page 17 W 255 V255 DEFICIENCY) Continued From page 17 W 255 W 455 LIPECTION CONTROL W 455 W 455 CFR(s): 483.470(I)(1) W 455 W 455 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infections and prevent possible cross-contamination. This potentially affected all the clients residing in the home. The findings are: A. During morning observations on 2/16/21 at 9:03am, the surveyor entered the home anager (HM). The HM stated the surveyor's temperature needed to be take prior to entering the home. The HM stated the surveyor's townowit on the anager (HM). The HM stated the surveyor's townowit on the forehead of the surveyor touching her skin. Observations revealed a bottle of hand sanitizer and a spray can of Lysol sitting on the table next to the front door. During an immediate interview, the HM stated the	

If continuation sheet Page 18 of 21

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G240	B. WING			02/ [,]	17/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICKEN	S DRIVE HOME				13 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 455	stated the digital the cleaned with either sanitizer on it or a a revealed the thermo- the skin of the perse- temperature taken. have been trained in thermometer while B. During morning 2/16/21 at 9:10am, from a hamper in the placed them into the 9:11am, client #2 we linen and putting it a prompted to wash h C. During morning of 2/16/21 at 9:53am, removed a glass from refrigerator, took a of poured it into the gla prompted to wash h Review on 2/17/21 of inservice dated 3/22 inserviced to accomp bathroom to ensure Review on 2/17/21 of guidelines (2020) st the bathroom (Ensu- route). 2. Assist cli 3. Assist client with client with applying antibacterial soap. 6. Client should rute	ermometer should always be a papertowel with hand alcohol wipe. Further interview ometer should never should on who is getting their The nurse also stated staff n the proper use of the the taking temperatures. observations in the home on client #2 removed dirty linen he laundry room area and e washing machine. At ras observed folding clean away. At no time was client #2 his hands. observations in the home on client #3 went into the kitchen om the cabinet, opened the container of milk out and ass. At no time was client #3	W 4	155			

If continuation sheet Page 19 of 21

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G240	B. WING			02/	17/2021
NAME OF F	PROVIDER OR SUPPLIER		· I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
DICKENS	S DRIVE HOME				13 DICKENS DRIVE ALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 455	Continued From pa	ige 19	W 4	55			
		on 2/16/21, the facility's nurse ts #2 and #3 hands should					
	4:05pm, client #4 us open a packet of ar pitcher of water. Fu client #4 used his m another packet of ir pitcher of water. Fu Staff C did not redir mouth/teeth to tear drink. Additional ob	tions in the home on 2/16/21 at sed his mouth/teeth to tear in instant drink and mix it in a urther observations at 4:07pm, nouth/teeth to tear open instant drink and mix it in a urther observations revealed rect client #4 from using his open the 2 packets of instant oservations revealed all 6 drinking from both pitchers of					
	client #4 should not	on 2/16/21, Staff C stated t have used his mouth/teeth to ckets of instant drink.					
	manager stated clie	on 2/17/21, the program ent \$3 should not have used pen the 2 packets of instant					
	2/17/21 at 5:40am, the door. Staff A pr temperature of the observations reveal	observations in the home on Staff A greeted the surveyor at roceeded to take the surveyor. Further led Staff A was wearing when he answered the door.					
	came from the back	te interview, Staff A said, "he k" wearing the gloves. Further Staff A should have removed opening the door.					
	During an interview	on 2/17/21, the qualified					

If continuation sheet Page 20 of 21

		AND HUMAN SERVICES				FORM	02/18/2021 APPROVED 0938-0391
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G240	B. WING	;		02/	17/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
DICKENS	B DRIVE HOME				13 DICKENS DRIVE RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 455	staff should not hav	ge 20 es professional (QIDP) stated ve been wearing the when he answered the door for	W 2	455			

Facility ID: 921760