| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| DICKENS DRIVE HOME | 113 DICKENS DRIVE RALEIGH, NC 27610 |

| (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 |
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| E 037 | EP Training Program<br>CFR(s): 483.475(d)(1)<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the | E 037 | | |

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

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| E 037 | Continued From page 1 | E 037 | | |

procedures necessary to protect patients and others.

(v) Maintain documentation of all emergency preparedness training.

(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) After initial training, provide emergency preparedness training every 2 years.

(iii) Demonstrate staff knowledge of emergency procedures.

(iv) Maintain documentation of all emergency preparedness training.

(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of all emergency

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| E 037 | Continued From page 2<br>preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected | E 037 | | |

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| E 037 | Continued From page 3<br>roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.<br><br>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.<br>This STANDARD is not met as evidenced by:<br>Based on document review and interviews, the facility failed to ensure direct care staff were adequately trained on the facility's emergency prepardness (EP) plan. The finding is:<br><br>Review on 2/16/21 of the facility's EP manual (2020) did not include any information regarding training of staff.<br><br>During an interview on 2/17/21, the program manager confirmed there was no information included in the EP concerning training of the staff. | E 037 | | |
| E 039 | EP Testing Requirements<br>CFR(s): 483.475(d)(2) | E 039 | | |

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| E 039 | Continued From page 4<br>*[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,<br>clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and | E 039 | | |

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| E 039 | Continued From page 5<br>maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For Hospices at 418.113(d):]<br>(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:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,<br>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 6<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop led by a facilitator that 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.<br>(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.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(2) Testing. The [PRTF, Hospital, CAH] must | E 039 | | |

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| E 039 | Continued From page 7<br>conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(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.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated,<br>clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(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.<br><br>*[For LTC Facilities at §483.73(d):]<br>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, | E 039 | | |

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| E 039 | Continued From page 8<br>including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. | E 039 | | |

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| E 039 | Continued From page 9<br>The ICF/IID must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated,<br>clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(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.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group | E 039 | | |

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| E 039 | Continued From page 10<br>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.<br>(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.<br>This STANDARD is not met as evidenced by:<br>Based on document review and interviews, the facility failed to ensure facility/community-based or tabletop exercises to test their Emergency Preparedness (EP) plan were conducted. This potentially affected all clients in the home. The finding is:<br><br>Review on 2/17/21 of the facility's EP plan dated January 2021, did not include a full-scale community-based or tabletop exercise for 2020.<br><br>During an interview on 2/17/21, the program manager revealed the facility did not perform a tabletop exercise for 2020. | E 039 | | |
| W 130 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(7)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and | W 130 | | |

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| W 130 | Continued From page 11<br>interviews, the facility failed to ensure privacy for 1 of 6 audit clients (#4) residing in the home. The finding is:<br><br>During morning observations in the home on 2/17/21 at 5:40am, client #4 exited the bathroom. Further observations revealed client #4 did not have any clothes on. Additional observations revealed client #3 turning to the right down the hall. At 5:42am, client #4 came back down the hall towards his bedroom and he was wearing just his underwear. During this time four other clients were up, dressed and walking though the home. At no time was client #4 prompted to put on his bathrobe.<br><br>During an immediate interview Staff A stated, "[Client #4] sleep in the nude." Further interview revealed client #4 needs to be reminded to put his bathrobe on.<br><br>During review on 2/17/21 of client #4's individual program plan (IPP) dated 3/10/20 stated, "NEEDS: Selects clothing for appropriate situations."<br><br>During an interview on 2/17/21, the program manager revealed client #4 should be reminded to put on his bathrobe before he exits his bedroom in the morning. | W 130 | | |
| W 189 | STAFF TRAINING PROGRAM<br>CFR(s): 483.430(e)(1)<br><br>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. | W 189 | | |

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| W 189 | Continued From page 12<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained in assisting clients with washing their hands. The finding is:<br><br>A. During morning observations in the home on 2/16/21 at 9:10am, client #2 removed dirty linen from a hamper in the laundry room area and placed them into the washing machine. At 9:11am, client #2 was observed folding clean linen and putting it away. At no time was client #2 prompted to wash his hands.<br><br>B. During morning observations in the home on 2/16/21 at 9:53am, client #3 went into the kitchen removed a glass from the cabinet, opened the refrigerator, took a container of milk out and poured it into the glass. At no time was client #3 prompted to wash his hands.<br><br>Review on 2/17/21 of facility hand washing inservice dated 3/23/20 revealed staff had been inserviced to accompany clients into the bathroom to ensure they wash their hands.<br><br>Review on 2/17/21 of the facility's hand washing guidelines (2020) stated, "1. Accompany client to the bathroom (Ensure nothing is touched in route). 2. Assist client with turning on the water. 3. Assist client with wetting hands. 4. Assist client with applying appropriate amount of antibacterial soap. 5. Start timer for 20 seconds. 6. Client should rub inside and outside of hands, in between fingers, and fingernails thoroughly."<br><br>During an interview on 2/16/21, the facility's nurse revealed both clients #2 and #3 hands should | W 189 | | |

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| | 34G240 | A. BUILDING _____ B. WING _____ | 02/17/2021 |

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| W 189 | Continued From page 13<br>have been washed. | W 189 | | |
| W 213 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)(ii)<br><br>The comprehensive functional assessment must identify the client's specific developmental strengths.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6) adaptive behavior inventory (ABI) have been done. The findings are:<br><br>A. Review on 2/16/21 of client #1's individual program plan (IPP) dated 2/4/21 revealed he was admitted to the facility on 2/1/20. Further review revealed client #1 does not have a ABI.<br><br>B. Review on 2/16/21 of client #2's IPP dated 7/7/20 revealed he was admitted to the facility on 4/4/92. Further review revealed client #2 does not have a ABI.<br><br>C. Review on 2/16/21 of client #3's IPP dated 4/11/20 revealed he was admitted to the facility on 4/30/92. Further review revealed client #3 does not have a ABI.<br><br>D. Review on 2/16/21 of client #4's IPP dated 3/10/20 revealed he was admitted to the facility on 2/1/00. Further review revealed client #4 does not have a ABI.<br><br>E. Review on 2/16/21 of client #5's IPP dated 6/9/20 revealed he was admitted to the facility on 4/21/92. Further review revealed client #5 does | W 213 | | |

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| W 213 | Continued From page 14<br>not have a ABI.<br><br>F. Review on 2/16/21 of client #6's IPP dated 8/4/20 revealed he was admitted to the facility on 8/21/04. Further review revealed client #6 does not have a ABI.<br><br>During an interview on 2/17/21, the program manager revealed the last time a ABI was done for the clients was in 2017. | W 213 | | |
| W 252 | PROGRAM DOCUMENTATION<br>CFR(s): 483.440(e)(1)<br><br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and interviews, the facility failed to ensure data was documented correctly. This affected 1 of 6 audit clients (#1). The finding is:<br><br>A. Review on 2/16/21 of client #4's behavior data revealed missing data for the following dates: 1/21 thru 1/24 and 2/3 thru 2/9/21. Further review revealed client #4 has a behavior intervention plan (BIP) dated 1/21 with the target behaviors of aggression, head or chest hitting and loud vocalizations. Client #4's BIP stated, "1. Frequency of all target behaviors should be documented on the behavior data sheets." Review of the behavior data sheets revealed there is a way to document if client #4 does not have any behaviors for the day. | W 252 | | |

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| W 252 | Continued From page 15<br><br>During an interview on 2/16/21, the qualified intellectual disabilities professional (QIDP) confirmed behavior data for client #4 should be documented daily.<br><br>B. During observations in the home on 2/16 and 2/17/21, client #4's fingernails had grown over the tip of his fingers.<br><br>Review on 2/17/21 of client #4's weekly hygiene/body check sheet revealed missing data for the following dates: 10/14; 10/21; 10/28; 11/4; 11/11; 11/18; 11/25; 12/2; 12/2; 12/9; 12/16; 12/23; 12/30; 1/6; 1/13; 1/29; 2/3; and 2/11. Part of the weekly hygiene/body check sheet had a place which states, "Do fingernails...need trimming...."<br><br>During an interview on 2/17/21, the home manager revealed the data for cutting client #4's fingernails should be documented every Wednesday of the week on second shift. | W 252 | | |
| W 255 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(1)(i)<br><br>The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 5 of 6 clients (#1, #2, #3, #5 and #6) individual program plan (IPP) were reviewed and/or revised as needed when the target date has passed. The findings are: | W 255 | | |

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| W 255 | Continued From page 16<br><br>A. Review on 2/16/21 of client #1's goals to brush his teeth and complete a purchase have a target date of 12/20. Further review revealed the goals have not been reviewed or revised.<br><br>B. Review on 2/16/21 of client #2's goals to complete a purchase and brush his gums have a target date of 12/20. Further review revealed the goals have not been reviewed or revised.<br><br>C. Review on 2/16/21 of client #3's goals to complete a purchase and shut the room and bathroom doors while dressing have a target date of 12/20. Further review revealed the goals have not been reviewed or revised.<br><br>D. Review on 2/16/21 of client #5's goals to floss teeth daily and complete a purchase have a target date of 12/20. Further review revealed the goals have not been reviewed or revised.<br><br>E. Review on 2/16/21 of client #6's goals to close the bathroom door while utilizing the bathroom and complete a purchase have a target date of 12/20. Further review revealed the goals have not been reviewed or revised.<br><br>During an interview on 2/16/21, the qualified intellectual disabilities professional (QIDP) revealed all the goals for clients #1, #2, #3, #5 and #6 have steps which are to be run one at a time until the client completes that step before moving on to the nest one. Further interview revealed all the steps have been running at the same time. The QIDP revealed the former QIDP had written the goals that way and she was unsure why they were written that way. Additional interview revealed the goals have a target date of | W 255 | | |

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| W 255 | Continued From page 17<br>12/20 and they need to be reviewed and or revised. | W 255 | | |
| W 455 | INFECTION CONTROL<br>CFR(s): 483.470(l)(1)<br><br>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.<br><br>This STANDARD is not met as evidenced by:<br>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:<br><br>A. During morning observations on 2/16/21 at 9:03am, the surveyor entered the home and the front door and was greeted 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.<br><br>During an immediate interview, the HM stated the digital thermometer was not sanitized prior to it touching the forehead of the surveyor.<br><br>During an interview on 2/16/21, Staff B stated the digital thermometer never touches the skin of anyone while their temperature is being taken.<br><br>During an interview on 2/16/21, the facility's nurse | W 455 | | |

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| W 455 | Continued From page 18 | W 455 | | |

stated the digital thermometer should always be cleaned with either a papertowel with hand sanitizer on it or a alcohol wipe. Further interview revealed the thermometer should never should the skin of the person who is getting their temperature taken. The nurse also stated staff have been trained in the proper use of the the thermometer while taking temperatures.

B. During morning observations in the home on 2/16/21 at 9:10am, client #2 removed dirty linen from a hamper in the laundry room area and placed them into the washing machine. At 9:11am, client #2 was observed folding clean linen and putting it away. At no time was client #2 prompted to wash his hands.

C. During morning observations in the home on 2/16/21 at 9:53am, client #3 went into the kitchen removed a glass from the cabinet, opened the refrigerator, took a container of milk out and poured it into the glass. At no time was client #3 prompted to wash his hands.

Review on 2/17/21 of facility hand washing inservice dated 3/23/20 revealed staff had been inserviced to accompany clients into the bathroom to ensure they wash their hands.

Review on 2/17/21 of the facility's hand washing guidelines (2020) stated, "1. Accompany client to the bathroom (Ensure nothing is touched in route). 2. Assist client with turning on the water. 3. Assist client with wetting hands. 4. Assist client with applying appropriate amount of antibacterial soap. 5. Start timer for 20 seconds. 6. Client should rub inside and outside of hands, in between fingers, and fingernails thoroughly."

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| W 455 | Continued From page 19 | W 455 | | |

During an interview on 2/16/21, the facility's nurse revealed both clients #2 and #3 hands should have been washed.

D. During observations in the home on 2/16/21 at 4:05pm, client #4 used his mouth/teeth to tear open a packet of an instant drink and mix it in a pitcher of water. Further observations at 4:07pm, client #4 used his mouth/teeth to tear open another packet of instant drink and mix it in a pitcher of water. Further observations revealed Staff C did not redirect client #4 from using his mouth/teeth to tear open the 2 packets of instant drink. Additional observations revealed all 6 clients in the home drinking from both pitchers of the instant drink.

During an interview on 2/16/21, Staff C stated client #4 should not have used his mouth/teeth to tear open the 2 packets of instant drink.

During an interview on 2/17/21, the program manager stated client $3 should not have used his mouth to tear open the 2 packets of instant drink.

E. During morning observations in the home on 2/17/21 at 5:40am, Staff A greeted the surveyor at the door. Staff A proceeded to take the temperature of the surveyor. Further observations revealed Staff A was wearing disposable gloves when he answered the door.

During an immediate interview, Staff A said, "he came from the back" wearing the gloves. Further interview revealed Staff A should have removed the gloves prior to opening the door.

During an interview on 2/17/21, the qualified

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| W 455 | Continued From page 20<br>intellectual disabilities professional (QIDP) stated staff should not have been wearing the disposable gloves when he answered the door for the surveyor. | W 455 | | |