PRINTED: 02/18/2021 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						E SURVEY IPLETED
		34G240	B. WING			02/17/2021	
	PROVIDER OR SUPPLIER S DRIVE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	*(For RNCHIs at §4* Hospitals at §482.1 at §484.102, "Orgal OPOs at §486.360, Training program. To following: (i) Initial training policies and proced staff, individuals program arrangement, and vexpected roles. (ii) Provide emetat least every 2 year (iii) Maintain do preparedness training (iv) Demonstrate emergency procedures are [facility] must condure policies and procedition and procedures are [facility] must condure policies and procedures are [facility] must condure policies and procedures are [facility] must condure the policies and procedures are [facility] must condure the policies and procedures are [facility] provide employees, services under arrangency procedures at least every 2 year (iv) Periodically emergency prepare employees (includin special emphasis pl	and and a second	E 0	037	E037 A review of ASI systems processes revealed that although staff of ASI had received training there was no evidence of EP train Dickens Drive Group Home on the past 18 months. The Program Director did reveal that she belies staff had been trained by the precept QP, however, there was no documentation on file. In addition the EP had been updated annual and addendums added as necesses especially concerning the recent COVID pandemic. To assure this not occur again, the facility will provide training on the EP to all simmediately. Additionally, training will be documented, and a test we provided to assure staff are family with all emergency procedures. Program Director will be responsifor providing the training and asset the HR Department receives appropriate documentation for existing staff. All new staff will be trained by the HR Director as part their onboarding. The HR Manage will be responsible for assuring a existing staff and new hires are trained initially and every year aft that. The Program Director will monitor the HR Manager's training logs at least quarterly to assure the all staff stay current on EP.	n the l, ning /er m ved vious n, lly sary, s will staff ng ill be iar The ible uring et of ger ll er g nat	X6) DATE

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.

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G240	B. WING _		02/1	17/2021
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E 037	others. (v) Maintain dod preparedness training (vi) If the emergand procedures are hospice must condupolicies and procedures. *[For PRTFs at §44 program. The PRTF (i) Initial training policies and procedustaff, individuals programs arrangement, and vexpected roles. (ii) After initial training (iii) Demonstrate emergency procedure (iv) Maintain dod preparedness training (v) If the emergand procedures are PRTF must conduct policies and procedures are PRTF must conduct policies and procedures are program. The LTC following: (i) Initial training policies and procedustaff, individuals programs and vexpected role. (ii) Provide eme at least annually.	cumentation of all emergency ng. pency preparedness policies significantly updated, the uct training on the updated ures. 1.184(d):] (1) Training must do all of the following: in emergency preparedness ures to all new and existing viding services under colunteers, consistent with their aining, provide emergency ng every 2 years. The staff knowledge of res. Cumentation of all emergency ng. Pency preparedness policies significantly updated, the training on the updated	E 03			

	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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E 037	*[For CORFs at §48 CORF must do all of (i) Provide initial preparedness policiand existing staff, in services under arrait consistent with their (ii) Provide emerat least every 2 year (iii) Maintain door (iv) Demonstrate emergency procedures are sponsibilities emergency plan with workday. The training instruction in the loc systems and signals (v) If the emergency plan with workday. The training instruction in the loc systems and signals (v) If the emergency plan with workday. The CAH at §485. The CAH must do an (i) Initial training policies and procedures are CORF must conduct reporting and exting and where necessal personnel, and guest cooperation with authorities, to all net individuals providing	e staff knowledge of ares. 85.68(d):](1) Training. The of the following: I training in emergency es and procedures to all new adviduals providing angement, and volunteers, expected roles. All new personnel must igned specific regarding the CORF's and 2 weeks of their first and program must include ation and use of alarm and firefighting equipment. Begency preparedness policies significantly updated, the training on the updated ares. 625(d):] (1) Training program. Il of the following: In emergency preparedness ares, including prompt uishing of fires, protection, ry, evacuation of patients, ets, fire prevention, and firefighting and disaster	E 037			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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E 037	roles. (ii) Provide emeral least every 2 years. (iii) Maintain dou (iv) Demonstrate emergency procedures are CAH must conduct policies and procedures and procedures and procedures and procedures and procedures and existing staff, in under arrangement, with their expected documentation of the demonstrate staff kin procedures. There are emergency prepared years. This STANDARD is Based on documentation of the demonstrate staff kin procedures. There are mergency prepared years. This STANDARD is Based on documentation of the demonstrate staff kin procedures. There are mergency prepared years. This STANDARD is Based on documentation of the demonstration	ergency preparedness training rs. cumentation of the training. e staff knowledge of tres. gency preparedness policies significantly updated, the training on the updated tres. 35.920(d):] (1) Training. The e initial training in emergency es and procedures to all new individuals providing services and volunteers, consistent roles, and maintain e training. The CMHC must nowledge of emergency after, the CMHC must provide dness training at least every 2 in not met as evidenced by: at review and interviews, the are direct care staff were on the facility's emergency	E 03				
E 039	manager confirmed	there was no information oncerning training of the staff. ments	E 039				

	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIED/OUR				IVI CI IVI	0. 0938-039	
	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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1	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	,	PROVIDER'S PLAN OF CORRECTION	1	(X5)	
l	TAG	REGULATORY OR LS	C IDENTIFYING INFORMATION)	TAG	`	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE	
ŀ						DEFICIENCY)	WATE L		
		*[For RNCHI at §403 HHAs at §484.102, ("Organizations" unde §485.920, RHC/FQF Facilities at §494.62] (2) Testing. The [facilito test the emergence must do all of the following of the following of the following of the following of the fact accessible, conduct exercise every 2 (B) If the [fact natural or man-made activation of the emergence exempt from engage community-based or functional exercise under the actual event. (ii) Conduct an accevery 2 years, opposite functional exercise under the actual event. (iii) Conduct an accevery 2 years, opposite functional exercise under the following of	3.748, ASCs at §416.54, CORFs at §485.68, OPO, er §485.727, CMHC at HC at §491.12, ESRD is lity] must conduct exercises y plan annually. The [facility] owing: a full-scale exercise that is ery 2 years; or community-based exercise is uct a facility-based functional years; or illity] experiences an actual emergency that requires regency plan, the [facility] ging in its next required individual, facility-based excise following the onset of diditional exercise at least the the year the full-scale or ider paragraph (d)(2)(i) of ted, that may include, but is wing: full-scale exercise that is individual, facility-based exercise or workshop that and includes a group	E 03	the contract of the contract o	E039 An evaluation of the curre practices at ASI regarding practithe EP exercises revealed that was ASI has provided an initial full so emergency exercise several year ago, as well as some table top exercises on a routine basis, we failed to meet the entire intent of regulation. To assure that this diwill be corrected and that it will noccur again, the Program Director will set up a monitoring tool to assure that EP exercises are conducted minimally at least every months which may include tableto exercise with a facilitator and clinically relevant scenarios, a full scale community-based exercise combination of these methods. Additionally, all training/exercises are documented to be placed in the P training file and kept with the dealth and Safety Officer (H&S Officer). The H&S Officer will nonitor all documentation on seminnual basis to assure full compliance of this regulation.	nt cing /hile rale rs this efficit or		
			e [facility's] response to and						
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	maintain documenta 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 hospical community based events (A) When a not accessible, conductional exercise (B) If the hose or man-made emerged of the emergency place exempt from engaging scale community-based functional exercise of the emergency place in Conduct and years, opposite the year	ation of all drills, tabletop regency events, and emergency plan, as needed. 18.113(d):] ices that provide care in the explored hospice must conduct the emergency plan at least ice must do the following: In a full-scale exercise that is every 2 years; or community based exercise is fluct an individual facility ercise every 2 years; or spice experiences a natural gency that requires activation and, the hospital is not in its next required full is ed exercise or individual facility ercise every 2 years; or spice experiences a natural gency that requires activation and, the hospital is not in its next required full is ed exercise or individual facility exercise every 2 years the full-scale or not independent of the full-scale or not paragraph (d) (2)(i) of context of the full-scale exercise that is a facility based functional disaster drill; or exercise or workshop that and includes a group	E O	39			

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			COMPLETED			
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(X4) ID PREFIX TAG	CARL DEFINITION IN ICT DE DOCUEDED DY FUIL				BE	(X5) COMPLETION DATE	
E 039	care directly. The hexercises to test theyear. The hospice (i) Participate is that is community-be. (A) When a not accessible, confacility-based function (B) If the horman-made emerof the emergency pexempt from engage full-scale community functional of the emergency e. (ii) Conduct and that may include, be following: (A) A second community-based of exercise; or (B) A moch (C) A table by a facilitator that it using a narrated, emergency scenarios statements, directed questions desemble emergency plan. (iii) Analyze the maintain document exercises, and emergency semerency the hospice's emergency semerency emergency semerency emergency semerency emergency plan. (iii) Analyze the maintain document exercises, and emergency semerency emergency semerency emergency semerency emergency emergency plan. (iii) Analyze the maintain document exercises, and emergency e	ices that provide inpatient hospice must conduct a emergency plan twice per must do the following: In an annual full-scale exercise assed; 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 ling in its next required by based or facility-based exercise following the onset ovent. In additional annual exercise and full-scale exercise that is or a facility based functional and full-scale exercise that is or a facility based functional and full-scale exercise that is or a facility based functional and full-scale exercise that is or a facility based functional and full-scale exercise that is or a facility based functional and full-scale exercise that is or a facility based functional and full-scale exercise that is or a facility based functional and facility-relevant or and a set of problem do messages, or prepared signed to challenge an endospice's response to and action of all drills, tabletop ergency events and revise gency plan, as needed. 1.184(d), Hospitals at	E	039			

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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E 039	conduct exercises to twice per year. The do the following: (i) Participate in that is community-b (A) When a not accessible, condition facility-based function (B) If the [P) experiences an acture emergency that requested for the following in its next based or functional exercise of the emergency event. (ii) Conduct an [and that may include following: (A) A second community-based or functional exercise; (B) A mock (C) A tableto is led by a facilitator discussion, using a reclinically-relevant set of problem states prepared questions emergency plan. (iii) Analyze the maintain documental exercises, and emergency exercises. *[For LTC Facilities at (2) The [LTC facility]	test the emergency plan [PRTF, Hospital, CAH] must In an annual full-scale exercise ased; or community-based exercise is duct an annual individual, onal exercise; or RTF, Hospital, CAH] Ital natural or man-made uires activation of the fe [facility] is exempt from required full-scale community individual, facility-based following the onset of the additional] annual exercise or a, but is not limited to the disaster drill; or op exercise or workshop that and includes a group narrated, at emergency scenario, and a ments, directed messages, or designed to challenge an alleadition of all drills, tabletop regency events and revise ency plan, as needed.	E 03	39			
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
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E 039	including unannoun emergency procedu ICF/IID] must do the (i) Participate ii that is community-be (A) When a not accessible, confacility-based function (B) If the [Li an actual natural or requires activation of the LTC facility is exrequired a full-scale individual, facility following the onset (ii) Conduct and that may include, but following: (A) A second (C) A table is led by a facilitator using a narrated, emergency scenarios tatements, directed questions desemble emergency plan. (iii) Analyze the response to and madrills, tabletop exercite events, and revise the emergency plan, as *[For ICF/IIDs at §44 (2) Testing. The ICF	ced staff drills using the ures. The [LTC facility, e following: n an annual full-scale exercise ased; or a community-based exercise is duct an annual individual, onal exercise. TC facility] facility experiences man-made emergency that of the emergency plan, tempt from engaging its next community-based or ty-based functional exercise of the emergency event. additional annual exercise of the emergency exercise or workshop that includes a group discussion, clinically-relevant or, and a set of problem of the exercise of the emessages, or prepared digned to challenge an exercise of problem of the exercise of problem of the exercise of the emergency he [LTC facility] facility's intain documentation of all the exercise of the emergency he [LTC facility] facility's needed.	E OS	39		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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E 039	that is community-b (A) When a not accessible, cond facility-based function (B) If the IC natural or man-mad activation of the emits exempt from engativation of the emergency existing the emergency plan. (iii) Analyze the emergency exercises, and emergency emergency exercises, and emergency emergency exercises, and emergency emergency exercises, and emergency exercises.	the following: an annual full-scale exercise ased; or community-based exercise is duct an annual individual, onal exercise; or. F/IID experiences an actual e emergency that requires ergency plan, the ICF/IID aging in its next required y-based or individual, facility- additional annual exercise that not limited to the following: d full-scale exercise that is r an individual, facility-based or disaster drill; or op exercise or workshop that and includes a group narrated, at emergency scenario, and a ments, directed messages, or designed to challenge an ICF/IID's response to and tion of all drills, tabletop gency events, and revise ency plan, as needed. 360] OPO must conduct exercises ex plan. The OPO must do the per-based, tabletop exercise annually. A tabletop exercise	E 03				

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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E 039	emergency scenarios statements, directions designed plan. If the OPO export man-made emergency pengaging in its next following the onset (ii) Analyze the maintain documents and emergency ever and OPO's] emerge This STANDARD is Based on document facility failed to ensuor tabletop exercise Preparedness (EP)	ge 10 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 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. In the total community of the lare facility/community-based s to test their Emergency plan were conducted. This all clients in the home. The	E 039				
W 130	January 2021, did n community-based of During an interview manager revealed the tabletop exercise for PROTECTION OF CCFR(s): 483.420(a). The facility must ensure the facil	CLIENTS RIGHTS (7) sure the rights of all clients. by must ensure privacy during	W 130				

	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	34G240	B. WING		02	/17/2021	
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ding is: uring morning observations 17/21 at 5:40am, of the observations we any clothes on the observations we all dient #3 tull. At 5:42am, clie Il towards his bed of this underwear. ents were up, dress me. At no time we his bathrobe. uring an immediate observations we aled client #4 new his bathrobe on. uring review on 2/1 ogram plan (IPP) of	ty failed to ensure privacy for #4) residing in the home. The ervations in the home on client #4 exited the bathroom. It is revealed client #4 did not and Additional observations from the right down the ent #4 came back down the room and he was wearing. During this time four other is sed and walking though the as client #4 prompted to put the interview Staff A stated, the nude." Further interview seds to be reminded to put 17/21 of client #4's individual dated 3/10/20 stated,	W 1	practices at Dickens Drive Grindome revealed a need to provadditional training to staff on consumer privacy. As a result this deficiency, all staff will rectaining on consumer privacy the next 14 days provided by Clinical Director or the ICF Program Director. The QP wiprovide at least monthly monit to assure that consumer privated are being met. Additional though training will be relativall of our consumers, the IPP consumer who prompted this deficiency will be reviewed to discuss whether there is a need include a privacy goal in the	oup vide of eive within he oring cy aally, e to of the	Within 14 days of approval of POC	
inager revealed clout on his bathrob droom in the morn AFF TRAINING P R(s): 483.430(e)(e facility must provial and continuing ployee to perform	ient #4 should be reminded e before he exits his ning. ROGRAM 1) vide each employee with training that enables the h his or her duties effectively,	W 18	39			
F COC ITHINVILLE THE THE PRODUCT SHIP	SUMMARY STA' (EACH DEFICIENCY REGULATORY OR LE CONTINUED FROM PARE PROPERTIES AND PARE PARE PARE PARE PARE PARE PARE PARE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 11 erviews, the facility failed to ensure privacy for of 6 audit clients (#4) residing in the home. The ding is: Iring morning observations in the home on 17/21 at 5:40am, client #4 exited the bathroom. In the observations revealed client #4 did not be any clothes on. Additional observations realed client #3 turning to the right down the lite. At 5:42am, client #4 came back down the lite towards his bedroom and he was wearing to this underwear. During this time four other ents were up, dressed and walking though the me. At no time was client #4 prompted to put his bathrobe. In an immediate interview Staff A stated, lient #4] sleep in the nude." Further interview ealed client #4 needs to be reminded to put bathrobe on. In greview on 2/17/21 of client #4's individual gram plan (IPP) dated 3/10/20 stated, EEDS: Selects clothing for appropriate	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 11 erviews, the facility failed to ensure privacy for of 6 audit clients (#4) residing in the home. The ding is: Iring morning observations in the home on 7/21 at 5:40am, client #4 exited the bathroom. There observations revealed client #4 did not eve any clothes on. Additional observations realed client #3 turning to the right down the latowards his bedroom and he was wearing this underwear. During this time four other ents were up, dressed and walking though the me. At no time was client #4 prompted to put his bathrobe. In the property of client #4 individual gram plan (IPP) dated 3/10/20 stated, lient #4] sleep in the nude." Further interview ealed client #4 needs to be reminded to put bathrobe on. In greview on 2/17/21 of client #4's individual gram plan (IPP) dated 3/10/20 stated, lient #4] sleep in the nude interview ealed client #4 should be reminded but on his bathrobe before he exits his from in the morning. AFF TRAINING PROGRAM R(s): 483.430(e)(1) Prefix TAG W 18 Fing an interview on 2/17/21, the program in the morning. AFF TRAINING PROGRAM R(s): 483.430(e)(1)	STREET ADDRESS, CITY, STATE, ZIP CODE 13 DICKENS DRIVE RALEIGH, NC 27610 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 11 erviews, the facility failed to ensure privacy for of 6 audit clients (#4) residing in the home. The ding is: Intinued From page 11 erviews, the facility failed to ensure privacy for of 6 audit clients (#4) residing in the home. The ding is: Intinued From page 11 erviews, the facility failed to ensure privacy for of 6 audit clients (#4) residing in the home. The ding is: Intinued From page 11 erviews, the facility failed to ensure privacy for of 6 audit clients (#4) residing in the home. The ding is: Intinued From page 11 erviews, the facility failed to ensure privacy for of 6 audit clients (#4) residing in the home. The ding is: Intinued From page 11 erviews, the facility failed to ensure privacy for of 6 audit clients (#4) residing in the home. The ding is client #4 on the home on 17/21 at 5:40am, client #4 exited the bathroom. The observations revealed client #4 did not we any clothes on. Additional observations revealed of lient #4 days provided by the client enterview and the was wearing it his underwear. During this time four other ants were up, dressed and walking though the lower with substance. Intinued From page 11 Everiews, the facility failed to ensure privacy for for 6 audit clients #4 did not on 17/21 at 5:40am, client #4 did not on consumer privacy. As a result this deficiency, all staff will revealed client #4 days provided by the next 14 day	STREET ADDRESS, CITY, STATE, ZIP CODE 113 DICKENS DRIVE RALEIGH, NC 27610 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY W 130 A review of systems and practices at Dickens Drive Group Home revealed a need to provide additional training to staff on consumer privacy. As a result of this deficiency, all staff will receive training on consumer privacy within the next 14 days provided by the clinical Director or the ICF Program Director. The QP will provide at least monthly monitoring to assure that consumer privacy needs are being met. Additionally, although training will be relative to all of our consumers, the IPP of the consumer who prompted this deficiency will be reviewed to discuss whether there is a need to include a privacy goal in the consumer's individual program plan (IPP) dated 3/10/20 stated, EEDS: Selects clothing for appropriate ations." W 189 STREET ADDRESS, CITY, STATE, ZIP CODE 113 DICKENS DRIVE RALEIGH, NC 27610 PROVIDER RALEIGH, NC 27610 PR	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G240	B. WING		02/	17/2021	
	PROVIDER OR SUPPLIER S DRIVE HOME		1	STREET ADDRESS, CITY, STATE, ZIP CODE 113 DICKENS DRIVE RALEIGH, NC 27610			
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W 189	This STANDARD is Based on observatinterviews, the facili sufficiently trained in washing their hands. A. During morning 2/16/21 at 9:10am, from a hamper in the placed them into the 9:11am, client #2 willinen and putting it a prompted to wash in B. During morning 2/16/21 at 9:53am, removed a glass from refrigerator, took a compoured it into the glaprompted to wash in Review on 2/17/21 conserviced to accombathroom to ensure Review on 2/17/21 conserviced to accombathroom (Ensuroute). 2. Assist client with client with applying a antibacterial soap. 6. Client should rubin between fingers, and the sufficient with an interview.	s not met as evidenced by: ions, record review and ty failed to ensure staff were n assisting clients with s. The finding is: observations in the home on client #2 removed dirty linen re laundry room area and re washing machine. At as observed folding clean away. At no time was client #2 ris 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 189	W189 A review of systems and practices at Dickens Drive Grot Home revealed that although of guidelines were in place regard handwashing, staff failed to add to those guidelines. To correct deficiency and assure it does no occur again, all staff will be trai in sufficient handwashing by the RN on proper handwashing as outlined in the guidelines. The training will be documented cle Program Director will monitor in and ongoing trainings on a more basis.	up lear ling nere this ot ned e ASI arly.	Within 30 days of approval of POC	

	STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			O. 0938-039* ATE SURVEY OMPLETED	
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NAME OF PROVIDER OR SUPPLIER DICKENS DRIVE HOME					1	STREET ADDRESS, CITY, STATE, ZIP CODE 113 DICKENS DRIVE RALEIGH, NC 27610	1 0	2/17/2021	
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		have been washed. INDIVIDUAL PROG CFR(s): 483.440(c)(The comprehensive identify the client's sistrengths. This STANDARD is Based on record revialled to ensure 6 of #4, #5 and #6) adapt have been done. The A. Review on 2/16/2 program plan (IPP) diadmitted to the facility revealed client #1 doi: B. Review on 2/16/2 7/7/20 revealed he was 4/4/92. Further review not have a ABI. C. Review on 2/16/2 4/11/20 revealed he won 4/30/92. Further review on 2/16/21 8/10/20 revealed he won 2/16/20 revealed he was 2/16/9/20 revealed he w	RAM PLAN 3)(ii) functional assessment must pecific developmental not met as evidenced by: view and interview, the facility 6 audit clients (#1, #2, #3, ive behavior inventory (ABI) e findings are: 1 of client #1's individual ated 2/4/21 revealed he was yon 2/1/20. Further review	W 1	:13	W213 A review of systems reve that an ABI had in fact not been completed since the previous QF was hired in 2017. Because ASI that QP who also managed anothome was not providing adequate services, we severed ties with he January and have hired a season ICF QP who understands the ICF regulations and ASI policies and procedures fully. To correct this deficiency, our current QP will develop a comprehensive function assessment by completing an adaptive behavior inventory (ABI) all consumers. The QP will complete an ABI on each consumannually as normal and customar planning in developing the annual IPP. The QP will review the resul with the treatment team so that the may monitor its completion annual	felt ner e r in ned on er	Within 60 days of approval of POC	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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2/16. d he er review aled a country is to be account in the country is to be a country in the co	(21 of client #6's IPP dated was admitted to the facility on eview revealed client #6 does on 2/17/21, the program the last time a ABI was done in 2017. MENTATION (1) complishment of the criterial advidual program plan documented in measurable s not met as evidenced by: intation review and interviews, ensure data was documented at a for the following dates: 2/3 thru 2/9/21. Further review has a behavior intervention 21 with the target behaviors of inchest hitting and loud in the target behavior should be behavior data sheets." vior data sheets revealed becument if client #4 does not		52	the recent Dickens Drive Group Is survey revealed deficiencies surrounding documentation of consumer goals. After reviewing electronic health records (EHR's) Clinical Director discovered severareas that needed to be address and staff trained correctly, as we goals updated. To correct this issouth the goals and objectives in the EHR system will be reviewed and updated in the system, and addit training will be provided and documented to all staff on how to enter appropriate documentation the system and to identify current goals and objectives in the system With the assistance of the agency tech support employee, the QP work to update all program data is EHR system and provide training	the), the ral ed ll as sue the into the m. y's vill n the to	Within 60 days of approval of POC
THOSE STATES AND THE SECOND STATES OF THE SECOND ST	PPLIER RY STACKING TO THE PRINCIPLE OF	AG240 PPLIER RRY STATEMENT OF DEFICIENCIES (CIENCY MUST BE PRECEDED BY FULL BY OR LSC IDENTIFYING INFORMATION) Dom page 14 BI. 1 2/16/21 of client #6's IPP dated end he was admitted to the facility on her review revealed client #6 does BI. Prview on 2/17/21, the program ended the last time a ABI was done was in 2017. POCUMENTATION 440(e)(1) to accomplishment of the criteria ient individual program plan list be documented in measurable ARD is not met as evidenced by: cumentation review and interviews, end to ensure data was documented affected 1 of 6 audit clients (#1).	A BUILDI 34G240 B. WING PLIER RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL (Y OR LSC IDENTIFYING INFORMATION) Dom page 14 B. (2/16/21 of client #6's IPP dated ed he was admitted to the facility on her review revealed client #6 does BI. Priview on 2/17/21, the program ealed the last time a ABI was done was in 2017. DOCUMENTATION 440(e)(1) To accomplishment of the criteria ient individual program plan ist be documented in measurable ARD is not met as evidenced by: cumentation review and interviews, ed to ensure data was documented a affected 1 of 6 audit clients (#1). 12/16/21 of client #4's behavior data sing data for the following dates: and 2/3 thru 2/9/21. Further review it #4 has a behavior intervention ied 1/21 with the target behaviors of ead or chest hitting and loud Client #4's BIP stated, "1. all target behaviors should be on the behavior data sheets." behavior data sheets revealed to document if client #4 does not	A BUILDING 34G240 B. WING PPLIER STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL IY OR LSC IDENTIFYING INFORMATION) The page 14 W 213 W 213 W 213 W 216/21 of client #6's IPP dated and he was admitted to the facility on her review revealed client #6 does I. Prefix Tag W 213 W 213 W 214 W 215 W 215 W 215 W 216/21 of client #6's IPP dated and he was admitted to the facility on her review revealed client #6 does II. Prefix Tag W 215 W 252 W	STREET ADDRESS, CITY, STATE, ZIP CODE 13 DICKENS DRIVE RALEIGH, NC 27610 PROVIDERS PLAN OF CORRECTION (EACH CORRECT WE ACTION SHOULD (RY OR LSC IDENTIFYING INFORMATION) DIPPERIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECT WE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) W 213 DIPPROVIDERS PLAN OF CORRECTION (EACH CORRECT WE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) W 213 W 213 W 2252 A review of systems follow the recent Dickens Drive Group is survey revealed deficiencies surrounding documentation of consumer goals. After reviewing electronic health records (EHR's) Clinical Director discovered seve areas that needed to be address and staff trained correctly, as we goals updated. To correct this is both the goals and objectives in the EHR system will be reviewed and updated in the system, and addit training will be provided and documented to all staff on how to enter appropriate documentation the system and to identify current goals and objectives in the system with the assistance of the agency tech support employee, the QP w work to update all program data is EHR system and provide training staff within 60 days of approval o plan of correction.	A BUILDING 34G240 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 113 DICKENS DRIVE RALEIGH, NC 27610 PROPIDER PROPIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DISTRICT ADDRESS, CITY, STATE, ZIP CODE 113 DICKENS DRIVE RALEIGH, NC 27610 PROPIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 213 W 213 W 213 W 214 W 215 W 252 A review of systems following the recent Dickens Drive Group Home survey revealed deficiencies surrounding documentation of consumer goals. After reviewing the electronic health records (EHR's), the Clinical Director discovered several areas that needed to be addressed and staff trained correctly, as well as goals updated. To correct this issue both the goals and objectives in the EHR system will be reviewed and updated in the system, and additional training will be provided and documented to all staff on how to enter appropriate documentation into the system and to identify current goals and objectives in the system, and additional training will be provided and documented to all staff on how to enter appropriate documentation into the system and to identify current goals and objectives in the system, and additional training will be provided and documented to all staff on how to enter appropriate documentation into the system and to identify current goals and objectives in the system, With the assistance of the agency's tech support employee, the QP will work to update all program data in the EHR system and provide training to staff within 60 days of approval of this plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G240		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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W 252	Continued From page	ge 15	W 2	52		
	During an interview on 2/16/21, the qualified intellectual disabilities professional (QIDP) confirmed behavior data for client #4 should be documented daily.					
	B. During observati 2/17/21, client #4's f tip of his fingers.	ons in the home on 2/16 and ingernails had grown over the			×	
	for the following date 11/11; 11/18; 11/25; 12/23; 12/30; 1/6; 1/ of the weekly hygien	of client #4's weekly sheet revealed missing data es: 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 e/body check sheet had a Do fingernailsneed				
W 255	During an interview of manager revealed the fingernails should be Wednesday of the w PROGRAM MONITO CFR(s): 483.440(f)(1	eek on second shift. DRING & CHANGE	W 25	5		
	least by the qualified professional and revibut not limited to situsuccessfully complet identified in the indiviorable This STANDARD is Based on record revialled to ensure 5 of (#6) individual program	sed as necessary, including, ations in which the client has ed an objective or objectives dual program plan. not met as evidenced by: iew and interview, the facility 5 clients (#1, #2, #3, #5 and m plan (IPP) were reviewed eded when the target date				

DICKENS DRIVE HOME (A4) ID PREFIX TAG (A5) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 255 Continued From page 16 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. D. Review on 2/16/21 of client #3's goals to complete a purchase have a target date of 12/20. Further review revealed the goals have not been reviewed or revised. 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. 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. 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. E. 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. 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. D. Review on 2/16/21 of client #5's goals to close the bathroom door while utilizing the bathroom and down while utilizing the bathroom and down while utilizing the bathroom and the steps necessary to assure the consumer's mastery of goals. After all staff are trained, the lead staff, with assistance from the tech support employee, wi		FEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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W 255 Continued From page 16 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. 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. 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. 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. E. Review on 2/16/21 of client #5'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. E. Review 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	DICKENS DRIVE HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				N BE	(X5) COMPLETION		
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. 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. 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. 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. E. 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. 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. 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	TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
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 25	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 whi of 12/20. Further renot been reviewed on D. Review on 2/16/2 teeth daily and complete date of 12/20. goals have not been E. Review on 2/16/2 the bathroom door wand complete a purchas and complete a purchas been reviewed on During an interview of 12/20. Further reviewed on the been reviewed on the policy of the bathroom door wand complete a purchas been reviewed on the been reviewed on the been reviewed on the been reviewed on the been reviewed all the goals and #6 have steps whime until the client comoving on to the nes revealed all the steps same time. The QID had written the goals unsure why they were	21 of client #1's goals to complete a purchase have a purchase have a purchese have a purchese have a purchesed. 21 of client #2's goals to be and brush his gums have a purchesed. 21 of client #3's goals to be and shut the room and le dressing have a target date of view revealed the prevised. 21 of client #5's goals to floss polete a purchase have a purchase have a purchesed for revised. 21 of client #6's goals to floss polete a purchase have a purchase have a further review revealed the previewed or revised. 21 of client #6's goals to close while utilizing the bathroom chase have a target date of the prevised. 22 of client #6's goals to close while utilizing the bathroom chase have a target date of the prevealed the goals have a target date of the prevealed the goals have a target date of the prevealed the goals have a target date of the prevealed the former quippersone. Further interview is have been running at the prevealed the former QIDP that way and she was the world way and she was the written that way. Additional	W2	?55	Dickens Drive Group Home reversible and in the steps that were developed to assure the consummastery of the goal. The second main concern is that the consum IPPs needed to be revised and updated. To correct this deficient the Clinical Director will review a update the IPP to current status, staff will be trained on current goand the steps necessary to assure the consumer's mastery of goals. After all staff are trained, the lead staff, with assistance from the test support employee, will monitor a goals to assure they are documented in a timely manner. Any issues will be escalated to the Clinical Director for retraining and	ng The not vely ner's d ners' ncy, nd All pals re d ch	Within 60 days of approval of POC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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W 255 W 455	12/20 and they need revised.	d to be reviewed and or	W 25 W 45	W/455 During all of 2020 and		Within 60 days of approval
	There must be an active program for the prevention, control, and investigation of infection and communicable diseases. 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:			infection control policies and procedures already in place were updated, revised and expanded, necessary. The RN conducted multiple trainings throughout our	e as	of POC
				agency. A review of systems and practices at ASI revealed that our staff were not abiding by training provided to them. As such, to contain this deficiency, the RN in partner with the Program Director and His	d r errect ship	
	9:03am, the surveyor front door and was go (HM). The HM state needed to be take porthe HM then placed directly on the foreign her skin. Observation	observations on 2/16/21 at or entered the home and the greeted by the home manager and the surveyors' temperature rior to entering the home. If the digital thermometer ead of the surveyor touching ons revealed a bottle of hand or can of Lysol sitting on the at door.		Manager will retrain all staff in infection control procedures and develop and conduct a thorough testing to assure that staff unders what is required of them and to prevent this deficiency from reoccurring. The HR manager w monitor trainings to assure all staff are in compliance and that staff a retrained each year on infection	ill iff	
		e interview, the HM stated the was not sanitized prior to it ad of the surveyor.		control policies.		
	digital thermometer	on 2/16/21, Staff B stated the never touches the skin of emperature is being taken.				
	During an interview	on 2/16/21, the facility's nurse				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.00	LTIPLE CONSTRUCTION DING		OATE SURVEY OMPLETED
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	NAME OF PROVIDER OR SUPPLIER DICKENS DRIVE HOME			STREET ADDRESS, CITY, STATE, ZIP 113 DICKENS DRIVE RALEIGH, NC 27610	CODE	271772021
(X4) ID PREFIX TAG			ID PREFI TAG	(N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	stated the digital the cleaned with either sanitizer on it or a a revealed the thermothe skin of the persetemperature taken. have been trained in thermometer while to the skin of the persetemperature taken. have been trained in thermometer while to the skin of the promoter while to the skin of	ermometer should always be a papertowel with hand lcohol wipe. Further interview ometer should never should on who is getting their. The nurse also stated staff in the proper use of the the aking temperatures. Observations in the home on client #2 removed dirty linen is laundry room area and washing machine. At as observed folding clean way. At no time was client #2 is hands. Observations in the home on client #3 went into the kitchen in the cabinet, opened the container of milk out and iss. At no time was client #3 s hands. If facility hand washing /20 revealed staff had been	W 4	1.55		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVICOMPLETED	
34G240		B. WING	B. WING			02/17/2021	
NAME OF PROVIDER OR SUPPLIER DICKENS DRIVE HOME				11	TREET ADDRESS, CITY, STATE, ZIP CODE 13 DICKENS DRIVE ALEIGH, NC 27610	1 021	1772021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	revealed both client have been washed. D. During observatid 4:05pm, client #4 us open a packet of an pitcher of water. Fur client #4 used his manother packet of in pitcher of water. Fur Staff C did not redire mouth/teeth to tear of drink. Additional obsclients in the home of the instant drink. During an interview of client #4 should not tear open the 2 packet. During an interview of manager stated client his mouth to tear open drink. E. During morning of 2/17/21 at 5:40am, Staff A protemperature of the since observations revealed disposable gloves with During an immediate came from the back!"	on 2/16/21, the facility's nurse is #2 and #3 hands should from the home on 2/16/21 at seed his mouth/teeth to tear instant drink and mix it in a rither observations at 4:07pm, outh/teeth to tear open stant drink and mix it in a ther observations revealed ect client #4 from using his open the 2 packets of instant servations revealed all 6 drinking from both pitchers of the 2/16/21, Staff C stated have used his mouth/teeth to tets of instant drink. On 2/17/21, the program of \$3 should not have used en the 2 packets of instant drink. On 2/17/21, the program of \$3 should not have used en the 2 packets of instant drink.	W 4	55	DEFICIENCY)		
	the gloves prior to op During an interview o	pening the door. on 2/17/21, the qualified					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY	7
-		34G240		B. WING	G	20//7/2		14710001	
		PROVIDER OR SUPPLIER S DRIVE HOME			STREET ADDRESS, CITY, STATE, ZI 113 DICKENS DRIVE RALEIGH, NC 27610	P CODE	02	02/17/2021	
	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI	ACTION SHOULD BE TO THE APPROPRIATE		(X5) COMPLETION DATE	1
	W 455	intellectual disabilities staff should not have	es professional (QIDP) stated	W					
						4)			