STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G240	A. BUILDING _____ B. WING _____	02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DICKENS DRIVE HOME	113 DICKENS DRIVE RALEIGH, NC 27610

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E 037	EP Training Program CFR(s): 483.475(d)(1) *[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: (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) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (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. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (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	E037 A review of ASI systems and processes revealed that although the staff of ASI had received training, there was no evidence of EP training in Dickens Drive Group Home over the past 18 months. The Program Director did reveal that she believed staff had been trained by the previous QP, however, there was no documentation on file. In addition, the EP had been updated annually and addendums added as necessary, especially concerning the recent COVID pandemic. To assure this will not occur again, the facility will provide training on the EP to all staff immediately. Additionally, training will be documented, and a test will be provided to assure staff are familiar with all emergency procedures. The Program Director will be responsible for providing the training and assuring the HR Department receives appropriate documentation for existing staff. All new staff will be trained by the HR Director as part of their onboarding. The HR Manager will be responsible for assuring all existing staff and new hires are trained initially and every year after that. The Program Director will monitor the HR Manager's training logs at least quarterly to assure that all staff stay current on EP.	

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

Tony S. Harris — Clinical Director, QP — 3/1/2021

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.

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E 037	Continued From page 1 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	E 037		

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E 037	Continued From page 2 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (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. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (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. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (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 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[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. This STANDARD is not met as evidenced by: 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: Review on 2/16/21 of the facility's EP manual (2020) did not include any information regarding training of staff. 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 CFR(s): 483.475(d)(2)	E 039		

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E 039	Continued From page 4 *[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]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (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. (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: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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. (iii) Analyze the [facility's] response to and	E 039	E039 An evaluation of the current practices at ASI regarding practicing the EP exercises revealed that while ASI has provided an initial full scale emergency exercise several years ago, as well as some table top exercises on a routine basis, we failed to meet the entire intent of this regulation. To assure that this deficit will be corrected and that it will no occur again, the Program Director will set up a monitoring tool to assure that EP exercises are conducted minimally at least every 6 months which may include tabletop exercise with a facilitator and clinically relevant scenarios, a full-scale community-based exercise, a functional facility-based exercise or a combination of these methods. Additionally, all training/exercises will be documented to be placed in the EP training file and kept with the Health and Safety Officer (H&S Officer). The H&S Officer will monitor all documentation on semi-annual basis to assure full compliance of this regulation.	

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E 039	Continued From page 5 maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (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: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (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. (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: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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.	E 039		

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E 039	Continued From page 6 (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: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (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. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (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. (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. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must	E 039		

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E 039	Continued From page 7 conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (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. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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. (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. *[For LTC Facilities at §483.73(d):] (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 including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (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. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (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. (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. *[For ICF/IIDs at §483.475(d)]: (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 The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (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. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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. (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. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (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 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. (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. This STANDARD is not met as evidenced by: 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: 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. 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 CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and	W 130		

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W 130	Continued From page 11 interviews, the facility failed to ensure privacy for 1 of 6 audit clients (#4) residing in the home. The finding is: 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. 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. 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." 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	W130 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.	Within 14 days of approval of POC
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) 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 This STANDARD is not met as evidenced by: 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: 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. 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. 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." During an interview on 2/16/21, the facility's nurse revealed both clients #2 and #3 hands should	W 189	W189 A review of systems and practices at Dickens Drive Group Home revealed that although clear guidelines were in place regarding handwashing, staff failed to adhere to those guidelines. To correct this deficiency and assure it does not occur again, all staff will be trained in sufficient handwashing by the ASI RN on proper handwashing as outlined in the guidelines. The training will be documented clearly. Program Director will monitor initial and ongoing trainings on a monthly basis.	Within 30 days of approval of POC

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

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W 189	Continued From page 13 have been washed.	W 189		
W 213	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(ii) The comprehensive functional assessment must identify the client's specific developmental strengths. This STANDARD is not met as evidenced by: 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: 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. 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. 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. 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. 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	W213 A review of systems revealed that an ABI had in fact not been completed since the previous QP was hired in 2017. Because ASI felt that QP who also managed another home was not providing adequate services, we severed ties with her in January and have hired a seasoned ICF QP who understands the ICF regulations and ASI policies and procedures fully. To correct this deficiency, our current QP will develop a comprehensive functional assessment by completing an adaptive behavior inventory (ABI) on all consumers. The QP will complete an ABI on each consumer annually as normal and customary planning in developing the annual IPP. The QP will review the results with the treatment team so that they may monitor its completion annually.	Within 60 days of approval of POC

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W 213	Continued From page 14 not have a ABI. 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. 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 CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: 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: 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	W252 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. 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.	Within 60 days of approval of POC

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W 252	Continued From page 15 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 observations in the home on 2/16 and 2/17/21, client #4's fingernails had grown over the tip of his fingers. 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...." 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 CFR(s): 483.440(f)(1)(i) 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. This STANDARD is not met as evidenced by: 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 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 #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 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	W255 A review of practices at Dickens Drive Group Home revealed 2 main areas of concern regarding the IPP and subsequent goals. The first area is that the goals were not being run sufficiently nor effectively and in the steps that were developed to assure the consumer's mastery of the goal. The second main concern is that the consumers' IPPs needed to be revised and updated. To correct this deficiency, the Clinical Director will review and update the IPP to current status. All staff will be trained on current goals 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, will monitor all goals to assure they are documented in a timely manner. Any issues will be escalated to the Clinical Director for retraining and evaluation of goals.	Within 60 days of approval of POC

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W 255	Continued From page 17 12/20 and they need to be reviewed and or revised.	W 255		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) 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: 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. During an immediate interview, the HM stated the digital thermometer was not sanitized prior to it touching the forehead of the surveyor. 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. During an interview on 2/16/21, the facility's nurse	W 455	W455 During all of 2020 and especially as the COVID pandemic swept across North Carolina, multiple infection control policies and procedures already in place were updated, revised and expanded, as necessary. The RN conducted multiple trainings throughout our agency. A review of systems and practices at ASI revealed that our staff were not abiding by training provided to them. As such, to correct this deficiency, the RN in partnership with the Program Director and HR Manager will retrain all staff in infection control procedures and develop and conduct a thorough testing to assure that staff understand what is required of them and to prevent this deficiency from reoccurring. The HR manager will monitor trainings to assure all staff are in compliance and that staff are retrained each year on infection control policies.	Within 60 days of approval of POC

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W 455	Continued From page 18 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."	W 455		

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W 455	Continued From page 19 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	W 455		

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