DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	06/11/2024

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DICKENS DRIVE HOME	**113 DICKENS DRIVE RALEIGH, NC 27610**

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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Emergency Preparedness Plan (EPP) was reviewed and updated at least every two years. The finding is: Review of the facility EPP on 6/11/24 revealed a facility EPP Manual which was last updated 10/20/21. Interview on 6/11/24 with the qualified intellectual disabilities professional (QIDP) revealed she believed there had been an updated version of the EPP Manual. However, the updated version was not produced.	E 004		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and	W 249		

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W 249	Continued From page 2	W 249		

interviews, the facility failed to ensure 1 of 5 audit clients (#5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of communication and behavior intervention. The finding is:

Observation in the home on 6/10/24 from 10:00am to 11:30am revealed client #5 wearing a plain, white t-shirt. He walked down the hallway twice with Staff A and removed his shirt. Staff B prompted him to put his shirt on. Client #5 made loud, yelling vocalizations three times. He then went outside with Staff B for 15 minutes. During afternoon observations from 3:30pm to 6:00pm, client #5 wore a paper, tear-free shirt as he assisted in meal prep with Staff A. Staff A was observed to give client #5 1/4 cup of Skittles twice during the meal prep time. No communication wallet was used with client #5 during the day.

Observations in the home on 6/11/24 from 6:15am to 9:30am revealed client #5 wearing a paper, tear-free shirt over his regular tshirt. Staff A was observed to give client #5 1/4 cup of Skittles in the staff office. He exited the office with Staff C to go to his room and watch television in the den. He made several loud, yelling vocalizations during the morning. No communication wallet was used for client #5 to communicate.

Review on 6/10/24 of client #5's IPP, dated 3/30/24, revealed he is non-verbal and communicates his needs and wants through gestures and body language. A communication wallet was successfully used in the past for client #5. Therefore, the team will work to reinitiate the

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W 249	Continued From page 3	W 249		

use of this for communication.

Further review of client #5's IPP revealed he has a history of shirt-tearing, aggression, and self-injury behavior (SIB). Due to an increase in his aggression, he no longer attends the day program and has a 1:1 staff at the home. In addition, unsuccessful attempts to use tear-resistant clothing led to the use of a token system. No paper, tear-free shirt was included in his current plan.

Review on 6/10/24 of client #5's behavior intervention plan (BIP), dated 4/1/24, revealed a goal to earn a token of 1 to 2 Skittles per 15 minute increment in which he does not tear his shirt. In addition, he may choose a preferred activity after each hour of not tearing his shirt. Client #5's shirts should be soft, with no labels and minimal seams. No paper, tear-free shirt was recommended in his current plan. In addition, alternative activities to include tearing magazines or shredding paper, should be offered throughout the day.

Review on 6/11/24 of the qualified intellectual disabilities professional (QIDP) progress notes, dated 5/31/24, revealed client #5's Velcro tear-away shirt was discontinued due to being ineffective.

Interview on 6/11/24 with Staff A revealed client #5 enjoys working in the kitchen and understands what is being said. A communication wallet is used with another client.

Interview on 6/11/24 with the QIDP revealed staff may have to try the tear-free shirt and switch to the regular shirt at times. The QIDP confirmed

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W 249	Continued From page 4 the token system within his BIP required regular reward intervals, requiring him to wear a regular shirt. Client #5 should be involved in a variety of preferred activities to keep him busy, and his communication of preferences should be assured.	W 249		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the behavior intervention plans (BIP) for 2 of 5 audit clients (#2 and #5) were reviewed and monitored by the human rights committee (HRC). The finding is: A. Review on 6/10/24 of client #2's record revealed a behavior intervention plan (BIP) dated 10/8/23, which included psychotropic medications Risperidone and Amantadine for behavior control. No HRC consent was located. B. Review on 6/10/24 of client #5's record revealed a behavior intervention plan (BIP) dated 4/1/24, which included psychotropic medications Keppra, Divalproex, Gabapentin, Vimpat, Rexulti, and Paroxetine for behavior. In addition, restrictions included a locked closet, isolated time out, and 1:1 staff assignment. No HRC was located. Interview on 6/11/24 with the qualified intellectual disabilities professional (QIDP) revealed updated	W 262		

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W 262	Continued From page 5 consent forms for the HRC were needed.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 5 audit clients (#2 and #5). The findings are: A. Review on 6/10/24 of client #2's record revealed a behavior intervention plan (BIP) dated 10/8/23, which included psychotropic medications Risperidone and Amantadine for behavior control. No guardian signature was located. B. Review on 6/10/24 of client #5's record revealed a behavior intervention plan (BIP) dated 4/1/24, which included psychotropic medications Keppra, Divalproex, Gabapentin, Vimpat, Rexulti, and Paroxetine for behavior. In addition, restrictions included a locked closet, isolated time out, and 1:1 staff assignment. The consent page was signed by the guardian with no date listed. In addition, the consent page failed to include restrictions of a locked closet door and 1:1 staff assignment. Interview on 6/11/24 with the qualified intellectual disabilities professional (QIDP) revealed updated consent forms were sent home with guardians and not returned yet.	W 263		

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W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the system for drug administration failed to ensure all drugs were administered in compliance with physician orders for 2 of 5 audit clients (#3 and #6). The findings are: A. Observation on 6/10/24 at 5:00pm revealed client #3 to attend medication administration with Staff D. Client #3 received one serving of Pepto Bismol 30ml and one Tegretol tablet 200mg. Review on 6/11/24 of client #3's available recent physician orders, dated 7/12/23, revealed at 5:00pm, he should receive one serving of Pepto Bismol 30ml, one Tegretol tablet 200mg, and one tablet Ferrous Sulfate 325 mg. B. Observation on 6/11/24 at 7:00am revealed client #6 to attend medication administration with Staff B. Client #6 received one Chlorpromazine tablet 25mg, one Vitamin D3 Capsule 50mcg, one Omeprazole capsule 20 mg, and one Ensure Boost carton. Staff B told client #6 that he was out of his Vitamin E capsules. Review on 6/11/24 of client #6's available recent physician orders, dated 7/12/23, revealed at 7:00am, he should receive one Chlorpromazine tablet 25mg, one Vitamin D3 Capsule 50mcg, one Omeprazole capsule 20 mg, one capsule Vitamin E 200 units, and one Ensure Boost carton. Interview on 6/11/24 with the qualified intellectual	W 368		

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W 368	Continued From page 7 disabilities professional (QIDP) confirmed that the 7/12/24 physician orders were the most current orders available in the home for clients #3 and #6.	W 368		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at least quarterly for each shift. The finding is: Review on 6/10/24 of the facility's fire drills conducted May 2023 through May 2024 revealed the following drills were missing: Quarter 1: First Shift, Quarter 2: First Shift, and Quarter 3: Third Shift. Interview on 6/11/24 with the qualified intellectual disabilities professional (QIDP) confirmed fire drills should be completed for each shift quarterly.	W 440		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure clients received a modified and specially-prescribed diet as indicated. This affected 1 or 5 audit clients (#6). The finding is: During dinner observations in the home on	W 460		

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W 460	Continued From page 8 6/10/24, client #6 was served and consumed one whole piece of grilled salmon, one serving of spinach, one sweet potato, one serving of rice, and a small bowl of slices peaches. The salmon was not cut into bite-sized pieces. During breakfast observation in the home on 6/11/24, client #6 was served one whole bagel, cereal, and sliced peaches. The bagel was not cut into bite-sized pieces. However, he did not eat his bagel. Review on 6/10/24 of client #6's individual program plan (IPP), dated 1/9/24, revealed a prescribed ADA diet with food cut into bite-sized pieces. Review on 6/11/24 of client #6's nutrition evaluation, dated May, 2024 revealed an ADA diet with meats and foods cut into bite-sized pieces to allow for easier chewing. Interview on 5/29/24 with the qualified intellectual disabilities professional (QIDP) revealed client #6 should have food cut into bite-sized pieces, as prescribed.	W 460		