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

PRINTED: 06/11/2024
FORM APPROVED
OMB NO. 0938-0391

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

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 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	E004 A review of systems revealed that there was an updated EPP, reviewed and dated on 10/27/2023 in the home office, however, the Dickens Drive group home staff stated they could not locate their updated copy. It is customary for ASI leadership to review, and/or update the EPP in October annually, and to distribute updated EPP's to the group home lead staff assure that the home also has an updated copy. To correct this deficiency, however, the copy kept in the home office was redistributed to the group home lead staff. The Program Director (or designee) will assure the updated copy is then placed in the group home and every October (or more often if necessary for special circumstances), the group home will also be provided an updated EPP every October to assure this deficiency doesn't occur again. RECEIVED JUN 27 2024 DHSR-MH Licensure Sect	8-1-2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	6-19-2024

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 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	W 249	W249 - Partly as a review of systems both internally and externally of active treatment as related to Client #5 (and all clients), improved active treatment programming guidelines were developed that that will correct the this deficiency, keep the consumer active and busy in a variety of meaningful activities, and will be documented appropriately, and follow the consumer's plan in active treatment. Several "stations" have been set up and a calendar of activities (both internally and externally) have been developed as well. To assure this deficiency doesn't occur again, there are several "layers" of monitoring have been added. An activities coordinator will monitor the documentation of the activities, as well as the lead staff, and finally the Clinical Director/QP. As related to client #5 more specifically, the client's active treatment plan will be implemented as the plan states, and any changes will be in writing, approved, and documented as any occurrences take place. Additionally, the wearing of or not wearing a paper shirt will be approved or disapproved by the Human Rights Committee and recommendations will be accepted by the HRC and in following ICF Rules and Regulations.	8-1-2024

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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	W262 - A review of systems revealed that 2 BIP's had inadvertently not been signed by the HRC, a policy and procedure mandated by ASI as well as ICF Rules and Regulations. As such, the Clinical Director/QP will assure all BIPs are submitted to the HRC for review and approval as the plans are developed and before they are implemented. The two plans in question will be submitted for approval to the HRC immediately. To assure this doesn't occur again, the Clinical Director/QP will maintain a spreadsheet of dates BIP's are updated and when HRC meetings, and assure moving forward that no BIP slip through the cracks without proper approval by the HRC and all concerned.	8-1-2024

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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	W263 - A review of ASI systems revealed that while consent forms, were sent home with guardians, they had not been signed and returned in an appropriate time creating this deficiency. To correct this deficiency, the Clinical Director/ QP contacted the guardians to assure the consents were read, understood by the guardians, and signed and returned to be placed in the consumers' files. To prevent this from occurring again, the Clinical Director/QP as an ongoing monitoring tool, included this on a spreadsheet to assure all consents were given to guardians and returned to ASI in a timely manner. The Clinical Director/QP will continue to monitor the consents to assure she or a designee receive the appropriate consents in a timely manner as required by ASI P&P, and NC ICF rules and regulations.	8-1-2024

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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	W368 - A review of systems revealed that all staff providing medications had been med trained sufficiently. However, from these errors, the staff involved were pulled out of the medication closet, retrained, and when the nurse felt they were competent to provide medication, allowed to pass medication again. Whether because of a med error or the medication being out, ASI takes any medication errors very seriously. Additionally, physician orders should be updated as consumers see the physician, normally on a minimum of quarterly, or more often if necessary. To prevent this from occurring again, ASI's RN (or designee) will assure that physician orders are in place in addtion to assuring that all staff be kept current in their medication administration training. ASI's RN will monitor the MAR's to assure compliance with physician orders and accuracy in medication administration at least monthly.	8-1-24 .

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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	W440 - A review of systems revealed that because our regular lead staff had been out on extended sick leave, the fire drills were not conducted by the interim lead staff which is unacceptable to ASI. To correct this issue, the lead staff will conduct quarterly fire drills on each shift, document the outcome, and send the results to the Program Director or designee to monitor the compliance of fire drills at least quarterly.	8-1-2024
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	W460 - A review of systems revealed that the staff assisting with meal preparation did not understand all the nuances with meal preparation. As such, all staff will be retrained on ADA meal diets and their requirements. To prevent this issue from occurring again, the lead staff, Program Director or designee will monitor meal preparation from staff to assure adherence to all required regulations requiring meal preparation at least monthly or more often as needed.	8-1-2024