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 _____	06/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 and interview, the facility failed to ensure clients were afforded privacy during medication administration. This affected 2 of 4 audit clients (#2 and #4). The finding is: During observations in the home on 6/24/25 at 7:10am, client #4 was in the medication room for morning med pass. Client #2 walked into the medication room and shuts the door behind him. Staff E did not ask client #2 to exit the room until he is finished with client #4's medications. Interview on 6/24/25 with the nurse revealed that only one client should be in the medication room at a time to ensure privacy. The nurse confirmed staff E should have asked client #2 to step out.	W 130		
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 reviews and interviews, the facility failed to ensure each client	W 249		

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

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 _____	06/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 1 received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of Behavior Support Plan (BSP) implementation. This affected 1 of 4 audit clients (#3). The finding is: During observations in the home on 6/23/25 from 3:45pm through 5:00pm, client #3 was observed in the kitchen assisting the home manager (HM) with preparing dinner. Review on 6/23/25 of client #3's record revealed a BSP dated 4/7/25 with identified target behaviors consisting of aggression, self injurious behavior and clothes tearing. Further review of the BSP revealed client #3 requires 1:1 male staff working with him due to aggressive behaviors as he will target female staff. Interview on 6/24/25 with the program director confirmed client #3 should be 1:1 with a male staff and while assisting the female HM in dinner prep, a male staff should have still be in the kitchen and within arms reach of the client.	W 249		
W 259	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Adaptive Behavior Inventory (ABI's) were updated as needed. This affected 4 of 4 audit clients (#2, #3, #4 and #5). The findings are:	W 259		

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 _____	06/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 259	Continued From page 2 Record review on 6/23/25 revealed no ABI's could be located in client #2, #3, #4 and #5's chart. Interview on 6/24/25 with the program director confirmed no ABI's had been completed for clients #2, #3, #4 and #5.	W 259		
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 restrictive behavior techniques for 2 of 4 audit clients (#3 and #5) were reviewed and monitored by the human rights committee (HRC). The findings are: A. Review on 6/23/2025 of client #3's Behavior Support Plan (BSP) dated 4/7/25 revealed target behaviors consisting of aggression, self injurious behavior and clothes tearing. Further review on 6/23/25 of client #3's BSP revealed a signature by HRC but no date of when it was signed. B. Review on 6/23/25 of client #5's BSP dated 7/7/24 listed the use of the medication Lexapro. Further review on 6/23/25 of client #5's BSP revealed a signature by HRC but no date of when it was signed. Interview on 6/24/25 with the program director confirmed that the HRC consent should be dated when signed.	W 262		

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 _____	06/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained to implement appropriate health and hygiene methods. This affected 3 of 4 audit clients (#2, #3 and #5). The findings are: A. During observations in the home throughout the survey on 6/23/25 through 6/24/25, client #2, #3 and #5's fingernails were noted to be very long. Record review on 6/24/25 for each client did not detail the client's capabilities to complete nail care independently. Interview on 6/23/25 with the home manager (HM) revealed that staff are responsible for cutting all client's nails. The HM confirmed that staff should be ensuring client's nail are clean and cut.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error.	W 369		

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 _____	06/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 369	Continued From page 4 This affected 2 of 4 audit clients (#2 and #5). The findings are: A. During observations of medication administration in the home on 6/23/25 at 4:46pm, staff B administered Ferosul, Tegretol, Pepto Bismol 30ml and 30ml's of orange juice to client #5. Review on 6/24/25 of client #5's physician's orders dated 2/16/25 revealed no order for 30ml's of orange juice with the medication pass. However, an order that stated no oranges, grape fruit or cabbage and no acidic juices. B. During observations of medication administration in the home on 6/24/25 at 7:11am, staff E administered Simvastatin to client #2. Review on 6/24/25 of client #2's physician's orders dated 2/16/25 revealed an order for Simvastatin 20mg, take one tab by mouth at bedtime. Interview on 6/24/25 with the facility nurse confirmed client #5 should not have received orange juice during medication pass. The nurse also confirmed client #2's Simvastatin is ordered for 7pm.	W 369		
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: The facility failed to assure fire drills were conducted quarterly for each shift of personnel as evidenced by interview and record verification. The finding is:	W 440		

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 _____	06/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 440	Continued From page 5 Review on 6/23/25 of the facility's fire drill evacuation reports revealed for the time period of July 2024 through June 2025 revealed the following quarterly reports: July 2024 - September 2024 there was no 2nd shift drill completed; there were no drills conducted quarterly for October 2024 - December 2024; and no second shift drill conducted for the April 2025 - June 2025 quarter. Interview with the program director confirmed that the fire drills that were reviewed were the only drills completed to her knowledge.	W 440		