STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G240	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DICKENS DRIVE HOME	113 DICKENS DRIVE , RALEIGH, North Carolina, 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
W0000	INITIAL COMMENTS A compliant survey was conducted during the recertification survey on 6/1 - 6/2/26 for intake #3028711. The complaint was substantiated with no deficiencies cited.	W0000		
W0229	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(i) The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome. This STANDARD is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to ensure objective statements were written in terms of a single behavioral outcome. This affected 3 of 3 audit clients (#1, #4 and #6). The finding is: A. Review on 6/1/26 of client #1's Individual Program Plan (IPP) dated 1/8/26 revealed objectives were not written with single behavioral outcomes. The objectives noted the following: 1) Client #1 will thoroughly brush his teeth and gumline with no more than 3 partial physical prompts, no more than 15% of the time. 2) Client #1 will independently reach out and shake the trainer's hand 24 out of 30 sessions. B. Review on 6/1/26 of client #4's IPP dated 4/3/26 revealed an objective was not written in terms of a single behavioral outcome. The objective noted the following: Client #4 will close his bedroom and bathroom door when getting dressed or undressed with no more than 3 verbal prompts and no more than 65% of the time. C. Review on 6/1/26 of client #6's IPP dated 2/16/26 revealed an objective was not written in terms of a single behavioral outcome. The objective noted the following: Client #6 will wash his hands after using the restroom and before eating meals with 3 partial physical and verbal prompts, no more than 85% of the time. Interview on 6/2/26 with the Program Manager (PM) confirmed the objectives were not written in terms of a single behavioral outcome.	W0229		

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 reverse for further 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.

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

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W0255	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 the Individual Program Plan (IPP) was reviewed and revised after 1 of 3 audit clients (#4) had successfully completed an objective. The finding is: Review on 6/1/26 of client #4's IPP dated 4/3/26 revealed an objective for client #4 to wear appropriate clothing with no more than 3 verbal prompts, no more than 65% of the time. Additional review of the record indicated the objective had been implemented over a year ago. Further review of progress notes for the objective for Nov '25, Dec '25, Jan '26, Feb '26 and March '26 all noted 66.4%. Interview on 6/2/26 confirmed based on the progress notes, client #4 appears to have completed the objective, however, training continues.	W0255		
W0257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Program Plan (IPP) was reviewed and revised as needed after 1 of 3 audit clients (#4) failed to progress towards identified objectives. The finding is: Review on 6/1/26 of client #4's IPP dated 4/3/26 revealed the following objectives had been implemented over a year ago: 1) Client #4 will let staff know when he had to use the restroom with no more than 3 verbal prompts, 75% of the time.2) Client #4 will identify the appropriate bathroom with no more than 3 verbal prompts and no more than 75%	W0257		

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W0257	Continued from page 2 of the time.3) Client #4 will say or signal to his housemate(s) to pass the serving dishes with no more than 3 verbal prompts, no more than 75% of the time.4) Client #4 will be able to complete a purchase with no more than 2 verbal prompts at least 45% of the time.5) Client #4 will thoroughly brush his teeth focusing along the gum line with no more than 1 verbal prompt, no more than 70% of the time.6) Client #4 will close his bedroom and bathroom door when getting dressed or undressed with no more than 3 verbal prompts, no more than 65% of the time. Additional review of progress notes for the objectives noted the following: Using the restroomNov '25, Dec '25, Jan '26, Feb '26 and March '26 = all 54.3% Id appropriate bathoomNov '25, Dec '25, Jan '26, Feb '26 and March '26 = all 68.7% Passing serving dishNov '25, Dec '25, Jan '26, Feb '26 and March '26 = all 58,6% Complete a purchaseNov '25, Dec '25, Jan '26, Feb '26 and March '26 = No progress notes Brushing teethNov '25, Dec '25, Jan '26, Feb '26 and March '26 = No progress notes Closing door for privacyNov '25, Dec '25, Jan '26, Feb '26 and March '26 = No progress notes Interview on 6/2/26 with the Program Manager (PM) confirmed the progress notes did not show improvements and needed to be revised.	W0257		
W0263	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 document review and interview, the facility failed to ensure written informed consent for client #6's restrictive Behavior Intervention Plan (BIP) was obtained from both guardians. This affected 1 of 3 audit clients. The finding is: Review on 6/1/26 of client #6's record revealed his parents were identified as his legal guardians. Additional review of the client's BIP dated 10/6/25 revealed objectives to display no more than 25 target behaviors as defined in his BIP and to have skin integrity rated no more than "1" for 2 or less times 6 out of 10 consecutive months. Further review of the plan included the use of Risperdal and Amantadine to address his behaviors. Review of a consent for the BIP noted only one of the two guardians had given written informed consent for the plan.	W0263		

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W0263	Continued from page 3 Interview on 6/2/26 with the Program Manage (PM) confirmed both guardians should have given written informed consent for the restrictive BIP.	W0263		
W0340	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, record review and interviews, the facility failed to ensure all staff were trained to provide clients with necessary support and guidance during the administration of their medications. This affected 2 of 3 audit clients (#4 and #6). The findings are: A. During morning observations of medication administration in the home on 6/2/26 at 7:03am, client #4 was called to the medication room to receive his medication. The client brought a cup of water into the room and sat in a chair nearby as the Medication Technician (MT) retrieved his medication bin (with his picture attached), pulled a pill card from the basket, punched the pill into a pill cup, told the client what the pill was, and gave pill cup to client #4. The client swallowed the pill and returned to empty pill cup to the MT. The MT threw the cup away and returned the medication bin to the shelf. Interview on 6/2/26 with the MT revealed what was observed is how client #4 normally participates during the administration of his medications. Review on 6/2/26 of client #4's Nursing Evaluation revealed the client can assist with the administration of his mediations by going to the bathroom to wash his hands after he is called, obtaining a glass of water, going to the medication room, obtaining his medication bin from the shelf, punching his pills from the blister pack into a pill cup, consuming his medication and returning his bin. Interview on 6/2/26 with the Home Manager (HM) and Program Manager (PM) confirmed client #4 can complete most task during the med pass including telling you what he's taking. The PM noted each client should consistently prompted to complete tasks during the administration of their medications. B. During morning observations of medication administration in the home on 6/2/26 at 7:13am, client #6 was called to medication room to receive his medication.	W0340		

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W0340	Continued from page 4 The client brought a cup of water into the room and stood nearby as the MT retrieved his medication bin (with his picture attached) , pulled out several pill cards from the basket, punched his pills into a pill cup, told the client the names of the pills, and gave the pill cup to client #6. The client ingested the pills, threw away the empty pill cup and left the room. Interview on 6/2/26 with the MT revealed what was observed is how client #6 normally participates during the administration of his medications. Review on 6/2/26 of client #6's Individual Program Plan (IPP) dated 2/16/26 revealed he participates with the administration of his medications by coming to the medication room when called, obtain his medication bin, punch his pills, place them in pill cups, obtain a glass of water, ingest his medications, throw away his trash and return the medication bin to the shelf. Interview on 6/2/26 with the HM and PM confirmed client #6 "can do it all" during the med pass and should be consistently assisted to complete all tasks as indicated.	W0340		
W0350	DENTAL SERVICES CFR(s): 483.460(e)(3) The facility must provide education and training in the maintenance of oral health. This STANDARD is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure education and training was provided for the maintenance of client #1's oral health. This affected 1 of 3 audit clients. The finding is: Review on 6/2/26 of client #1's dental examination report dated 12/30/25 revealed he had received a cleaning. The report also noted his oral hygiene was "poor". Additional review of the client's Individual Program Plan (IPP) dated 1/8/26 indicated an objective to thoroughly brush his teeth and gum line which had been implemented over a year ago. Interview on 6/2/26 with the Home Manager (HM) indicated client #1's oral hygiene is generally "fair - poor" and dental cleanings can be difficult for him. The HM indicated staff have been trained to provide toothbrushing for all client's at least three times daily. Interview on 6/2/26 with the Program Manager (PM) revealed she was not aware of any additional training or guidance provided to staff and/or client #1 to address his poor oral hygiene.	W0350		

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W0356	COMPREHENSIVE DENTAL TREATMENT CFR(s): 483.460(g)(2) The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure client #4 received comprehensive dental treatment for the maintenance of his dental health. This affected 1 of 3 audit clients. The finding is: Review on 6/2/26 of client #4's dental examination report dated 4/23/25 revealed, "Needs full mouth scaling, root planning...Needs #4 and #12 extractions...Need #13, 15, 30 fillings...Return for routine 6 month exam/cleaning and restorative". Additional review of the record did not include a current dental visit. Interview on 6/2/26 with the Home Manager (HM) indicated, as of the dated of the survey, client #4 has not returned to the dentist for a six month exam or to have the restorative work done as recommended by the dentist. Interview on 6/2/26 with the Program Manager (PM) revealed the HM is responsible for scheduling all appointments and client #4 should have returned for the recommended dental work.	W0356		
W0436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is NOT MET as evidenced by: Based on observations, record review and interview, the facility failed to ensure client #4 was provided necessary adaptive equipment as indicated. This affected 1 of 3 audit clients. The finding is: During observations in the home throughout the survey on 6/1 - 6/2/26, client #4 did not wear eyeglasses. The client was not provided with or prompted to wear eyeglasses. Interview on 6/2/26 with the Home Manager (HM) revealed client #4 does not have any eyeglasses and does not wear	W0436		

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W0436	Continued from page 6 eyeglasses. Review on 6/2/26 of client #4's vision examination report dated 4/14/25 revealed he has "excellent distance vision". Additional review of the report noted a recommendation for "+ 1.50 reading glasses when working at near". Interview on 6/2/26 with the Program Manager (PM) confirmed no reading glasses have been obtained for client #4 as recommended.	W0436		
E0013	Development of EP Policies and Procedures CFR(s): 483.475(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters	E0013		

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E0013	Continued from page 7 likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is NOT MET as evidenced by: Based on observations, document review and interviews, the facility failed to ensure the Emergency Preparedness Plan (EPP) included policies and procedures to address and manage equipment failure in the home. The finding is: Upon arrival to the home on 6/1/26 at 8:20am, the temperature in home felt warm in and around the living room, dining room and two office areas at the back of the home. Client's bedroom and bathroom areas of the home were cool. Closer observation of a thermostat on the wall in the dining room revealed the temperature was 76 degrees in the home. Ceiling fans were running continuously in the living room and dining room. Immediate interview with the Home Manager (HM) revealed the facility maintenance person had been at the home earlier to check their air conditioning system but it remained warm certain areas of the home. The HM noted she had called him to come back and recheck the system. Later observations in the home at 3:30pm revealed the temperature was 81 degrees. Additional interview with the HM revealed the maintenance person had returned to the home that afternoon and indicated the thermostat my need to be replaced, however, a Heating Ventilation Air Conditioning (HVAC) person would be coming to the home the next morning to assess the system. Review on 6/2/26 of the facility's EPP (last reviewed on 11/1/25) revealed no policies and procedures to address an equipment failure such as the HVAC	E0013		

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E0013	Continued from page 8 system. Interview on 6/2/26 with the Program Manager confirmed the EPP does not include specific policies and procedures regarding equipment failure resulting in extreme heat/cold in the home.	E0013		