		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		34G143	B. WING				C 18/2018
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
KEYWEST	CENTER				22 ATHENS AVENUE URHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 122	CLIENT PROTECTIC CFR(s): 483.420	DNS	W	122			
	The facility must ensu protections requireme						
	The facility failed to: written policies and pr neglect of the clients investigations (W154)	the Health Care Personnel					
W 149	The cumulative effect resulted in the facility statutorily mandated (STAFF TREATMENT CFR(s): 483.420(d)(1	Client Protections. OF CLIENTS	W	149			
	policies and procedur	elop and implement written res that prohibit t or abuse of the client.					
	Based on observation reviews, the facility ne policies and procedur implemented in order future elopements and	not met as evidenced by: ns, interviews and record eglected to assure written res were developed and to prevent the potential for d client neglect. This slients (#1 and #6). The					
	 The facility did not procedures in place to elopements. 	have written policies and o address client #1's					
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		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.

PRINTED: 07/02/2018

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/02/2018 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		34G143	B. WING			_		C 18/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KEYWES	T CENTER				1722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 149	Review on 6/18/18, of committee minutes re- incidents reports date 6/4/18, were all elope facility did not develop improvement plan to a behavior. Review on 6/18/18 of an admission date of intellectual diagnosis. Review of the three in following as identified a. Review on 6/18/18 5/31/18 at 6:30pm rev defiant and would not comply with house rul the side kitchen door 2 houses. Staff ran ar and urged [Client #1] [Client #1] complied a b. Review on 6/18/18 6/2/18 at 6:30pm reve bathe. When asked a no. Staff left his room front area dressed in sweats) and exited th- and headed in the dire contacted he was retu with snacks (Coke & p ate his snacks, contin made a second attem he observed staff"	f the human rights evealed the following ed 5/31/18, 6/2/18 and ments for client #1. The p and implement a behavior address this elopement client #1's record revealed 4/20/18 and a moderate client reports revealed the client report dated vealed, "[Client #1] became clisten to staff's Request to les. [Client #1] walked out and walked down the street and caught up with [Client #1] to come back to the house	W	149				

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/02/2018 // APPROVED). 0938-0391	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		34G143	B. WING			_	C 06/18/2018		
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
KEYWEST	CENTER			1	722 ATHENS AVENUE				
NETWEOT	GENTER			C	OURHAM, NC 27707				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
TAG W 149	Continued From page Staff rode the neighbor Staff asked cashier at client. They reported pork skins, & Coca-co store after no one gav street. Staff rode the a locate client. 911 was client given and office facility for picture of cl info Staff continue Client was located at brought back to facilit noted" During an interview of Durham Police record "Incident/Investigation was made on 6/4/18 f was no other informat information was also surveyors for review of Police records depart During an interview of confirmed she was un behaviors which inclu amongst other unider overtures from his pat interview confirmed cl behavior plan to addre address elopement(s)	e 2 prhood looking for client. It the store if they had seen yes he was asking for cig., pla. Cashier report client left we him cig. and went up the area of hwy 55 unable to contacted full description of er notified and dispatched to lient and other identifying d riding looking for client. local convenience store and ychecked for injury none n 6/18/18 via telephone, the is department identified an, n report for a Missing Person for [Client #1]" and there tion available. This made available to the via fax from the Durham ment. n 6/18/18, the administrator naware client #1 had target ded leaving the facility tified behaviors of sexual st placement. Further lient #1 did not have a		149]				
	During observations i	es. Additionally, she be called for elopements. In the home on 6/18/18, Id interacted well with staff							

Facility ID: 922086

If continuation sheet Page 3 of 21

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 07/02/2018 1 APPROVED 2: 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G143	B. WING		_	06/ [.]	; 18/2018	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-		
KEYWEST	CENTER			722 ATHENS AVENUE URHAM, NC 27707				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 149	shake to greet both su an one-on-one staff c observations in the ho observations in the ho olight of duty. 2. Staff neglected to call-in-procedure and working hours. Review on 6/18/18 of 5/23/18 at 5:00am rev 4:45 I heard what was closing shut coming fr called for [Client #6] to day room with me. un 5:00am I started bath things for a shower ou entering her room I of out an out fit top and bra and underwear. A [Client #6] to ask her she had taken out, thi injury to her right eye happened to her eye bed.'[Client #6] was compress was applied of moderate intellectu with Dementia, bilater Cataracts. This staff w staff working on this s	nt #1 eagerly and is hand out first for a hand urveyors. Client #1 was with onstantly throughout one on 6/18/18. There were nent noted during ome. Additional one on 6/18/18, the staff to e positive and there were 3 follow the facility's third shift was sleeping during an incident report dated realed, "At or about 4:30 - a believed to be a drawer om [Client #6's] room. I o come up front to sit in the til I started baths. At s I went to get [Client #6] ut of her room. Upon oserved that she had taken oants as well as socks, a at this point I looked at to help put away the clothes s is when I noticed major I asked [Client #6] what she responded 'I fell out my a taken to the ER, cold d." Client #6 has diagnosis al disabilities and diagnosed al Glaucoma and bilateral vas noted to be the only hift. As a result of this een in the emergency room,	W 149					

Facility ID: 922086

If continuation sheet Page 4 of 21

						IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
			A. BOILDING			С
		34G143	B. WING		0	6/18/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
KEYWEST	CENTED			1722 ATHENS AVENUE		
KET WEST	CENTER			DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
W 149	Continued From page	۵ ۵	W 14	10		
		of client #6's bedroom on	VV 1-	+9		
		night stand has relocated				
		ext to the wall across from				
		no furniture located next to				
	-	light has been placed in her				
	bedroom to provide to	or lighting during the night.				
	Review on 6/18/18 of	the incident report interview				
		ember (no date) revealed this				
	staff was being invest					
	Further review of this					
		Inteered recollections and				
		name] stated the following: e had fallen asleep in the				
	-	ubsequently wakened at				
		at she took to be the sound				
	of the closing of one of					
		her stated that she did not				
	• •	6's] face when she entered at [Client #6] made no				
	-	jury. During this time, [staff]				
	-	e couch in the day room.				
		ney watched TV for a while				
		aff] stated she again fell				
	-	5 AM; at which time she left				
		ent to the bedroom area of her client" Further review				
	of this document cond					
	recommendations:, ".					
	employment be termi	nated"				
	Review on 6/19/19 of	the facility's third shift				
		ed 12/31/13 revealed,				
	"Purpose: To ensure					
	requirements of having	ng staff awake on siteThis				
		nird party independence				
		articipation to help ensure				
	triat starr is awake an	d alert between the hours of				

Facility ID: 922086

If continuation sheet Page 5 of 21

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE COMF	
		34G143	B. WING				0 18/2018
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
KEYWES ⁻	I CENTER				22 ATHENS AVENUE URHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 149 W 154	the hour and make the - I have looked in on a consumers in the faci are required to check least hourly.) - I am a require any assistance normally Each state Each staff should end the hour as possible Review on 6/18/18 of 5/23/18 was the last of home and for the faci letter of resignation to During an interview of confirmed she fell out injured her eye. She has been moved arout During an interview of confirmed these incid interview confirmed these incid interview confirmed these incid interview revealed whethere appeared to be During observations i staff to client interacti staffing was appropriate STAFF TREATMENT CFR(s): 483.420(d)(3)	e following announcements: all consumers, and all lity are alive and well (you in on each consumer at lert, and functioning, I do not e The facility is operating aff call will be recorded deavor to call as close to on " staff's time sheet revealed date staff worked in the lity. This staff submitted her the facility on 6/1/18. n 6/18/18, client #6 to fher bed, when she further stated her furniture and since her fall. n 6/18/18, the administrator ents did occur. Additional the staff should have been menting per the third shift ich she did not do. Further then this staff was working a pattern of client injuries. n the home on 6/18/18, the ons were positive and ate 3 staff. OF CLIENTS () e evidence that all alleged	W	149			

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PRINTED: 07/02/2018

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 07/02/2018 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G143	B. WING		_		C 18/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KEYWEST	CENTER			722 ATHENS AVENUE URHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 154	Based on interview a facility failed to condu all alleged violations t admitted audit client (Client #1's three elope were not investigated 1. Review on 6/18/18 admitted into the facil moderate intellectual 6/18/18 of an incident 6:30pm revealed, "[Cl would not listen to sta house rules. [Client # kitchen door and walk houses. Staff ran and and urged [Client #1] [Client #1] complied a 2. Review on 6/18/18 6/2/18 at 6:30pm reve bathe. When asked a no. Staff left his room front area dressed in sweats) and exited th and headed in the dire contacted he was retu with snacks (Coke & p ate his snacks, contin made a second attem he observed staff" 3. Review on 6/18/18 6/4/18 at 3:30pm reve Staff rode the neighbor Staff asked cashier at	not met as evidenced by: nd document reviews the ct thorough investigations of his affected 1 of 1 newly #1). The findings are: ements from the facility a revealed client #1 was ity on 4/20/18 with a diagnosis. Review on report dated 5/31/18 at ient #1] became defiant and ff's Request to comply with e1] walked out the side ted down the street 2 caught up with [Client #1] to come back to the house	W 154				

If continuation sheet Page 7 of 21

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/02/2018 // APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G143	B. WING			_		C 18/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KEYWEST	CENTER				1722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 154	cig., pork skins, & Coc client left store after n went up the street. St unable to locate client description of client gi dispatched to facility f identifying info Sta for client. Client was store and brought bac injury none noted" During an interview of confirmed the facility f investigations concern STAFF TREATMENT CFR(s): 483.420(d)(4 The results of all inve- to the administrator of or to other officials in within five working da This STANDARD is r Based on record revi failed to assure the re- reported to the Health (HCPR) within five wor required by NC Gene finding is: An investigation and t reported to the HCPR a. Review on 6/18/18	orted yes he was asking for ca-cola. Cashier report o one gave him cig. and aff rode the area of hwy 55 t. 911 was contacted full iven and officer notified and for picture of client and other iff continued riding looking located at local convenience ck to facilitychecked for n 6/18/18, the administrator had not conducted any ning client #1's elopements. OF CLIENTS) stigations must be reported r designated representative accordance with State law ys of the incident. not met as evidenced by: ew and interview, the facility sults of an investigation was n Care Personnel Registry orking days of the incident as ral Statute 131E-256. The		154	•			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 34G143 B. WING 06/18/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE	07/02/2018 APPROVED 0938-0391
34G143 B. WING 06/18/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE	URVEY
1722 ATHENS AVENUE	8/2018
KEYWEST CENTER 1722 ATHENS AVENUE	
DURHAM, NC 27707	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BECOTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)DEFICIENCYCO	(X5) COMPLETION DATE
W 156 Continued From page 8 W 156 The five day investigation report has not been submitted as 6/18/18 and no request for an extension had been submitted. b. Review on 6/18/18 of the human rights committee minutes revealed three separate incident reports of elopements for client #1 dated 5/31/18, 6/2/18 and 6/4/18, all were not reported to HCPR. During an interview on 6/18/18 via telephone, the Durham Police records department identified an, "Incident/Investigation report for a Missing Person was made on 6/4/18 for [Client #1]" and there was no other information available. This information was also made available to the surveyors for review via fax from the Durham Police records department. During an interview on 6/18/18, the administrator confirmed no information or a request for an extension has been submitted to the HCPR. W 158 FACILITY STAFFING W 158 FACILITY STAFFING W 158 CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: The facility failed to: assure the qualified intellectual diabilities professional (QIDP) coordinated, integrated and monitored the programs for 1 of 1 audit clients in the home (W159) and facility did not provide sufficient direct care staff to manage and supervise clients (W186).	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
						С
		34G143	B. WING		0	5/18/2018
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
KEYWESI	CENTER			1722 ATHENS AVENUE		
				DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
W 158	Continued From page	e 9	W 158			
		r failed to provide statutorily				
	mandated facility staf	fing requirements.				
W 159			W 159			
	CFR(s): 483.430(a)					
	Each client's active tr	eatment program must be				
	integrated, coordinate	ed and monitored by a				
		disability professional.				
	Based on interviews	not met as evidenced by: record review and				
		ility failed to assure the				
		disabilities professional				
		i individual program plan nprovement plan (BIP) for 1				
		audit clients (#1). The				
	findings are:					
	The OIDD did not do	valan aliant #11a IDD nor				
		velop client #1's IPP nor ent a needed BIP to address				
	target behaviors of el					
	Review on 6/18/18 of	f client #1's record revealed				
		the facility on 4/20/18 with a				
		disabilities diagnosis. t reveal an IPP nor a BIP.				
		i leveai all IFF 1101 a DIF.				
	Review on 6/18/18, o					
		evealed the following incident				
		8, 6/2/18 and 6/4/18, all three d there was no behavior plan				
	to address this eloper	-				
	a. Review on 6/18/18	8 of an incident report dated				
		vealed, "[Client #1] became				
	defiant and would not	t listen to staff's Request to				
		les. [Client #1] walked out				
		and walked down the street nd caught up with [Client #1]				
				1		1

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I						FORM): 07/02/2018 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	34G143	B. WING _			_	06/	C 18/2018
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
KEYWEST CENTER				22 ATHENS AVENUE JRHAM, NC 27707			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 [Client #1] complied a b. Review on 6/18/18 6/2/18 at 6:30pm reverses bathe. When asked a no. Staff left his room front area dressed in a sweats) and exited the and headed in the direcontacted he was returned with snacks (Coke & p ate his snacks, contined made a second attem he observed staff" c. Review on 6/18/18 6/4/18 at 3:30pm reverses Staff rode the neighbor Staff asked cashier at client. Staff asked cashier at client. Staff asked cashier at client left store after n went up the street. Staff or client left store after n went up the street. Staff or client gi dispatched to facility fi identifying info Staff or client. Client was store and brought bac injury none noted" 	to come back to the house nd came back." a of an incident report dated saled, "[Client #1] refused to a second time, he told staff b. [Client #1] came to the clothing (Jacket, white e door. He refused to return ection of the store. 911 was urned by the Durham Police borkskins), At 7:30pm. He ued to refuse a bath and pt to leave the building but of an incident report dated saled, "[Client #1] left facility. orhood looking for client. the store if they had seen shier at the store if they had orted yes he was asking for ca-cola. Cashier report o one gave him cig. and aff rode the area of hwy 55 t. 911 was contacted full ven and officer notified and or picture of client and other ff continued riding looking located at local convenience ek to facilitychecked for	W 1	59				

Facility ID: 922086

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/02/2018 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G143	B. WING		_	(/06) 18/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
KEYWES	CENTER			1722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 159	During an interview o confirmed the facility current 2018 IPP nor During observations i client #1 was calm an and other clients. Clin his hand out first for a surveyors. Client #1 v one-on-one staff throughome on 6/18/18. During observations i staff to client interaction the one on 6/18/18. During observations i staff to client interaction to client interaction the facility must provide the client observations the facility staff to implement the (IPP) and provide new audit client (#1, #3 and The findings are:	n 6/18/18, the administrator had not established a a BIP for client #1. In the home on 6/18/18, ind interacted well with staff ent #1 independently stuck a hand shake to greet both was with a constant ughout observations in the In the home on 6/18/18, the ons were positive and ate 3 staff. FF -2) ide sufficient direct care supervise clients in individual program plans. lefined as the present ed over all shifts in a 24-hour ed residential living unit.	W 15	9			

Facility ID: 922086

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		34G143	B. WING			C 06/18/2018		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
KEYWEST	KEYWEST CENTER				1722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
W 186	 a. Review on 6/18/18 6/2/18 at 6:30pm reveloathe. When asked a no. Staff left his room front area dressed in sweats) and exited th and headed in the dir contacted he was retu- with snacks (Coke & ate his snacks, contin- made a second attern he observed staff" During interview on 6 revealed the staffing I supervision was not p elopement incident of During observations i client #1 was calm an and other clients. Cli- his hand out first for a surveyors. Client #1 w one-on-one staff throo home on 6/18/18. During observations i staff to client interacti staffing was appropria b. Review on 6/18/18 6/4/18 at 3:30pm reve Staff asked cashier at client. Staff asked cas seen client. They rep cig., pork skins, & Co client left store after m 	8 of an incident report dated ealed, "[Client #1] refused to a second time, he told staff h. [Client #1] came to the clothing (Jacket, white e door. He refused to return ection of the store. 911 was urned by the Durham Police porkskins), At 7:30pm. He used to refuse a bath and opt to leave the building but /18/18, the administrator has been skeletal and 1 on 1 but in place until this last ccurred. In the home on 6/18/18, id interacted well with staff ent #1 independently stuck a hand shake to greet both vas with a constant ughout observations in the In the home on 6/18/18, the ons were positive and		180				

Facility ID: 922086

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
34G143			B. WING			06/18/2018		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
KEYWES	CENTER				1722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 186	unable to locate client description of client g dispatched to facility fi identifying info Sta for client. Client was store and brought bac injury none noted" During interview on 6 revealed the staffing fi supervision was not p elopement incident of During an interview o Durham Police record "Incident/investigation was made on 6/4/18 was no other informat information was also surveyors for review o Police records depart During an interview o confirmed these incid for the facility had bee has not been staffed further stated she was prior behaviors of whi facility amongst other his past placement. S prepared to deal with overtures." Further in to be two staff on all s During observations i client #1 was calm an and other clients. Client	t. 911 was contacted full iven and officer notified and for picture of client and other off continued riding looking located at local convenience ck to facilitychecked for /18/18, the administrator has been skeletal and 1 on 1 but in place until this last ccurred. In 6/18/18 via telephone, the ds department identified an, n report for a Missing Person for [Client #1]" and there tion available. This made available to the via fax from the Durham ment. In 6/18/18, the administrator ents did occur. The staffing en skeletal and the facility like it should have. She is unaware client #1 had ch included leaving the unidentified behaviors from She stated, "I am not a runner or one with sexual iterview revealed there are shifts and it has not been. In the home on 6/18/18, id interacted well with staff ent #1 independently stuck a hand shake to greet both		180	6			

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PRINTED: 07/02/2018

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/02/2018 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G143	B. WING		_		C 18/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
KEYWEST	CENTER			722 ATHENS AVENUE OURHAM, NC 27707			
			I	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 186	Continued From page	: 14	W 186				
		ughout observations in the					
	During observations in staff to client interaction staffing was appropriated to the staffing was						
	4/27/18 at 5:00am rev [Client #3] for a show [Client #3's] soap from the shower running [C the shower alone. [Cli entrance to the show staff could catch her. intellectual diagnosis noted to be the only s	of an incident report dated vealed, "After undressing er staff turned around to get in her bathroom bin. Hearing Client #3] proceeded to enter ent #3] tripped over the er causing her to fall before Client #3 is blind and her is profound. This staff was taff working on this shift. As client #3 was seen in the e to injury to her					
	the home and for the her letter of resignation	the last date staff worked in facility. This staff submitted on to the facility on 6/1/18. In the home on 6/18/18, the ons were positive and					
	dated 5/23/18 at 5:00 4:30 - 4:45 I heard wh drawer closing shut co room. I called for [Clie sit in the day room wit At 5:00am I started ba things for a shower ou	B of client #6's incident report am revealed, "At or about nat was believed to be a coming from [Client #6's] ent #6] to come up front to th me. until I started baths. aths I went to get [Client #6] ut of her room. Upon oserved that she had taken					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/02/2018 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>				(X3) DATE SURVEY COMPLETED	
34G143			B. WING			_		C 18/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KEYWEST				17	722 ATHENS AVENUE			
NETWEO1	OENTER			D	URHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 186	bra and underwear. A [Client #6] to ask her she had taken out, thi injury to her right eye. happened to her eye bed.'[Client #6] was compress was applied level is moderate and Dementia, bilateral GI Cataracts. This staff w staff working on this s injury client #6 was se due to trauma to her e Review on 6/18/18 of with involved staff me "From her own volu my questions, [staff's Shortly after 3 AM she day room. She was se about 4:30 AM by wha of the closing of one of drawers [Staff] furth	At this point I looked at to help put away the clothes s is when I noticed major I asked [Client #6] what she responded 'I fell out my s taken to the ER, cold d." Client #6's functioning has been diagnosed with aucoma and bilateral vas noted to be the only hift. As a result of this een in the emergency room, eye. the incident report interview mber (no date) revealed, inteered recollections and name] stated the following: e had fallen asleep in the ubsequently wakened at at she took to be the sound of [Client #6's] chest her stated that she did not 6's] face when she entered		186		DEFICIENCY)		
	complaint about an in remained lying on the According to [staff], th during which time [sta asleep and awoke at	jury. During this time, [staff] couch in the day room. hey watched TV for a while iff] stated she again fell 5 AM; at which time she left ont to the bedroom area of						
	call-in-procedure date "Purpose: To ensure requirements of havin							

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/02/2018 // APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G143	B. WING			_		C 18/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
KEYWEST CENTER					722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 186	that staff is awake and 11pm and 6a.m. Proo the hour and make th - I have looked in on a consumers in the faci are required to check least hourly.) - I am al require any assistance normally Each stat Each staff should end the hour as possible Review on 6/18/18 of revealed 5/23/18 was the home and for the her letter of resignation During an interview of confirmed these incid has been skeletal and been. Further intervie should not have been been calling in and/or shift call-in-procedure Additional interview of staff on all shifts. During observations in staff to client interaction staffing was appropria STAFF TRAINING PF CFR(s): 483.430(e)(1 The facility must prov- initial and continuing to	articipation to help ensure d alert between the hours of bedure: Staff must call in on e following announcements: all consumers, and all lity are alive and well (you in on each consumer at lert, and functioning, I do not e The facility is operating aff call will be recorded leavor to call as close to on " staff's time schedule the last date staff worked in facility. This staff submitted on to the facility on 6/1/18. n 6/18/18, the administrator ents did occur. The staffing d there shifts and it has not ew confirmed the staff sleeping and should have d ocumenting per the third which she did not do. onfirmed there are to be two n the home on 6/18/18, the ons were positive and ate 3 staff. ROGRAM) ide each employee with training that enables the his or her duties effectively,		186				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/02/2018 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
34G143			B. WING		_		18/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KEYWEST	CENTER			1722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 189	Continued From page	9 17	W 189				
	Based on interviews, observations, the faci were sufficiently traine effectively and efficier audit clients (#1 and # 1. Staff were not train elopement behaviors. Review on 6/18/18 of dated 5/31/18, 6/2/18 elopements from the Review on 6/18/18 of he was admitted into Further review of clier an individual program address the elopement During an interview of confirmed the facility address elopement, the facility had a client wi 911 would be called w Further interview confibe behaviors were not pa behavior plan is need Additionally, the psyci- vacation; therefore no established to address needs. During observations in client #1 was calm an and other clients. Clief	ed to work with client #1's client #1's incident reports and 6/4/18 revealed three facility. client #1's record revealed the facility on 4/20/18. nt #1's record did not reveal plan nor a behavior plan to nt behavior. n 6/18/18, the administrator did not have a policy to his was the first time the th elopement behaviors and when client #1 elopes. firmed the elopement art of a behavior plan and a ed to address his behaviors. hologist has been on behavior plan has been s any of his behavioral n the home on 6/18/18, d interacted well with staff ent #1 independently stuck					
	911 would be called w Further interview cont behaviors were not pa behavior plan is need Additionally, the psyc vacation; therefore no established to addres needs. During observations in client #1 was calm an and other clients. Clie	when client #1 elopes. firmed the elopement art of a behavior plan and a ed to address his behaviors. hologist has been on b behavior plan has been s any of his behavioral n the home on 6/18/18, d interacted well with staff					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/02/2018 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVE COMPLETED C	
34G143			B. WING		_		」 18/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KEYWEST CENTER				722 ATHENS AVENUE URHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 189	home on 6/18/18. During observations in staff to client interactions staff to client interactions staffing was appropria 2. Staff were not adece blind and visually imp Review on 6/18/18, or report dated 4/27/18 f following: "On April 27 preparation of the res the shower occurred. been undressed and The attendant staff was collecting and moving bathroom bin to begin resident moved to ster waiting of for or before assistance. She is ver however, she then stu and tripped over the r attempted but was un which happened quict assisted to her feet. T who was attending an occurrence." This fall client's right shoulder. Review on 6/18/18 of revealed 5/23/18 was the home and for the her letter of resignations During observations in	vas with a constant ughout observations in the in the home on 6/18/18, the ons were positive and ate 3 staff. quately trained to work with aired clients. If an internal investigation for client #3, revealed the 7, 2018 in the process of ident for bath time, a fall in Resident, [Client #3] had the shower was running. as present and was i items. i.e. Soap, from the in the clients shower. The p into shower alone without e she could be given ry familiar with the facility, umbled (she is legally blind) aised entrance. Staff able to prevent the fall kly. The resident was 'his was reported by staff ad was the witness to this resulted in a fracture to	W 189				

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		34G143	B. WING		C 06/18/2018		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
KEYWEST	CENTER			1722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 189	Continued From page	9 19	W 1	89			
W 226	Staff interview on 6/12 worked at the facility if had not received any working with blind and During an interview of intellectual disabilities confirmed he was not provided to staff conce and visually impaired During observations if worked with client #3 During observations if staff to client interactions staff to client interactions attributed with client #3 INDIVIDUAL PROGR CFR(s): 483.440(c)(4 Within 30 days after at interdisciplinary team client, an individual pro- This STANDARD is m Based on record revit failed to assure the in	8/18, revealed they have for a long period of time and training from this facility on d visually impaired clients. In 6/18/18, with the qualified a professional (QIDP) aware of any facility training erning working with blind clients. In the home on 6/18/18, staff without any problems noted. In the home on 6/18/18, the ons were positive and ate 3 staff. AM PLAN) admission, the must prepare, for each rogram plan.	W 2				
	30 days after admissi newly admitted audit	on into the facility for 1 of 1 client (#1). The finding is: program plan (IPP) was not					
		client #1's record revealed					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/02/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		34G143	B. WING			_		18/2018
NAME OF PF	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
KEYWEST	CENTER				722 ATHENS AVENUE URHAM, NC 27707			
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID			PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
W 226		- 00						
VV 220	1.0	the facility on 4/20/18.	VV.	226				
		t reveal an established and						
		n 6/18/18, the qualified						
		IPP had not been developed						
	within 30 days of his a							

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