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

PRINTED: 08/08/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
34G143		B. WING _		C 08/03/2018		
NAME OF PROVIDER OR SUPPLIER  KEYWEST CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707	1 00/0	3/2010
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 122	CFR(s): 483.420	sure that specific client	W 12:	2		
W 127	This CONDITION is not met as evidenced by: The facility failed to: assure the clients were not subjected to physical abuse (W127) and to implement procedures to take appropriate corrective action to reasonably prevent the possibility of abuse, neglect, mistreatment or injury from potentially occurring to clients (W157).  The cumulative effect of this practice resulted in the facility's failure to provide statutorily mandated services of client protections to its clients.  The survey team determined as a result of this deficient practice a situation of immediate jeopardy (IJ) existed at the facility. The facility implemented corrective action and the IJ was removed.		W 12	TITLE		X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		34G143	B. WING				C <b>03/2018</b>
NAME OF PROVIDER OR SUPPLIER  KEYWEST CENTER				1722	EET ADDRESS, CITY, STATE, ZIP CODE 2 ATHENS AVENUE RHAM, NC 27707	1 00/	03/2010
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W 127	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W				
	confinement, or pucause or causes phemotional: Abusive interactions with or served that may resnegative reaction. is not limited to the or may not be intenpunishment, depriv	king, tripping unreasonable shing in a manner that may sysical harm or injury B. verbal or nonverbal in the presences of individuals sult in distress, fear or a Emotional abuse includes but following examples which may tional: 1. Threatening ation or physical violence of g, teasing, taunting, scolding,					

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34G143		B. WING			C 08/03/2018		
NAME OF PROVIDER OR SUPPLIER  KEYWEST CENTER				1	TREET ADDRESS, CITY, STATE, ZIP CODE 722 ATHENS AVENUE DURHAM, NC 27707	00/	00/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE	
W 127	PROVIDER OR SUPPLIER  ST CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		W	127			

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NAME OF PROVIDER OR SUPPLIER  KEYWEST CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 1722 ATHENS AVENUE DURHAM, NC 27707	DE	00/1	30,2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
W 127	by DHSR. 2. Pendi above referenced is be in the [Facility's member is present same restrictions lis STAFF TREATMEN CFR(s): 483.420(d)	en assessed and responded to ing resolution by DHSR of the issue, [QIDP's name] can only name]while another staff and she is subject to the isted in item 1 above."  IT OF CLIENTS  (4)  on is verified, appropriate	W 1				
	Based on an intervised facility failed to take action to prevent the mistreatment and/or 1 sampled client (#  The corrective mean of client abuse, mist occurring was not puring a complaint qualified intellectua (QIDP) was intervised a different client the client #1. During the revealed, "No staff, allowed to touch the I have shoved. If a shove them out of rewhomever you wan asked a client [Client over 3 times."	sure to prevent the possibility treatment or injury from provided.  investigation on 8/2/2018, the I disabilities professional ewed by both surveyors about an revealed information about its interview the QIDP including myself are not eclients push, shove, hit. Yes, client gets in my space I will my space. You can take that to t. Yes, I will shove, if I have int #1] to move out of my space					
	Review on 8/2/18 o	f the facility's policy 00028					

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NAME OF PROVIDER OR SUPPLIER  KEYWEST CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707	•	03/2016
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W 157	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 1	57		