STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G143	A. BUILDING ______ B. WING ______	C 09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYWEST CENTER	1722 ATHENS AVENUE DURHAM, NC 27707

(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
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an emergency preparedness (EP) plan including the geographic location of the facility and the clients' needs of the facility in the risk assessment, utilizing an all-hazards approach. The finding is:	E 006		

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

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E 006	Continued From page 1 The facility did not have an emergency plan based upon risk assessments. Review on 9/18/18, of the facility's current EP plan revealed the plan did not provide specific information in regards to the geographic location of the facility and the clients' needs of the facility in the risk assessment, utilizing an all-hazards approach. Interview on 9/18/18 with the qualified intellectual disabilities professional (QIDP) revealed she was aware of this and would be working to correct this issue with the EP plan.	E 006		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(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 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	E 013		

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E 013	Continued From page 2	E 013		

emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters 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 annually.

*[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 annually. 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 interview, the facility failed to develop specific policies and procedures to address emergency preparedness, considering risk assessment and their communication plan in case of an emergency evacuation of the clients in the facility. The finding is:

During an interview on 9/18/18, with management revealed they did not have policies and procedures specifically for the emergency preparedness plan. However, they have been working to update and develop their policies and procedures.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3)	E 032		

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E 032	Continued From page 3	E 032		

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(3) Primary and alternate means for communicating with the following:
(i) [Facility] staff.
(ii) Federal, State, tribal, regional, and local emergency management agencies.

*[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.
This STANDARD is not met as evidenced by:
Based on documentation and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is:

The facility failed to develop an alternate means for communicating with staff, regional and local governments during an emergency.

Review on 9/18/18, of the facility's emergency preparedness (EP) plan did not include any information regarding alternate means of communication.

During an interview on 9/18/18, management revealed if the land line phone and staff cell service were down they had not established an alternative way to communicate during an emergency.

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E 036	Continued From page 4	E 036		
E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing	E 036		

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E 036	Continued From page 5 and orientation program must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to develop a emergency preparedness (EP) training and testing program. The finding is: The facility failed to develop an emergency preparedness training and testing program. Review on 9/18/18 of facility's EP manual did not include any information on training or testing of the facility's staff. Staff (2) interview in the home on 9/18/18, concerning the EP plan revealed the following information, they had not been trained on the emergency preparedness. During an interview on 9/18/18, management revealed they had not provided training and testing for the EP plan.	E 036		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to assure allegations was reported immediately to the facility administrator or	W 153		

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W 153	Continued From page 6 designee as well as the Health Care Personnel Registry (HCPR) within twenty-four hours as required by NC General Statute 131E-256. This deficient practice was evident in 1 of 1 investigations. The finding is: Review on 9/18/18, of investigation performed by an independent outside agency revealed the allegations did not reported to the incident immediately to the facility administrator or designee and the health care personnel registry (HCPR) within twenty-four hours. During an interview on 9/18/18, with management revealed the HCPR was not notified within twenty-four hours as required by NC General Statute 131E-256. However, they would be reporting and understood it was late.	W 153		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure the results of an investigation was reported to the Health Care Personnel Registry (HCPR) within five working days of the incident as required by NC General Statute 131E-256. The finding is: Review on 9/18/18, of investigation performed by an independent outside agency revealed the allegations had not been reported to health care	W 156		

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W 156	Continued From page 7 personnel registry (HCPR) within five working days of the incident as required by NC General Statute 131E-256. During an interview on 9/18/18, with management revealed the HCPR was not notified within five working days of the incident as required by NC General Statute 131E-256. However, they would be reporting and understood it was late.	W 156		
W 351	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(1) Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain in a timely manner a dental examination for 1 newly admitted client (#1). The finding is: The facility failed to obtain a dental examination for client #1 within 30 days of admission. Review on 9/18/18 of client #1's individual program plan (IPP) dated 6/23/18, revealed he was admitted to the facility on 4/20/18. Further review of client #1's record revealed he had not received a dental examination.	W 351		

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W 351	Continued From page 8 During an interview on 9/18/18, the qualified intellectual disabilities professional (QIDP) stated she was aware client #1's had not received a dental examination. However, the primary care physician had made a referral for him to a UNC dentist.	W 351		
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 observations, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the Individual Program Plan (IPP) in the area of diet consistency. This affected 1 of 4 audit clients (#4). The finding is: Client #4's diet consistency was not followed. During dinner observations in the home on 9/18/18, client #4's dinner consisted of meatloaf, rice and squash. Further observations revealed staff cutting client #4's meatloaf into square type pieces. Additional observations revealed client #4 consuming 2 - 3 pieces of the meatloaf at one time. During an interview on 9/18/18, staff indicated client #4's food is "blended." Further interview revealed "blended" food should "blended up real fine."	W 460		

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

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W 460	Continued From page 9	W 460		

Review on 9/19/18 of client #4's nutrition evaluation dated 8/1/17 stated, "Oral...requiring chopped foods...Intervention 1. Continue chopped diet...."

Review on 9/19/18 of client #4's Food Card dated 8/2018 indicated, "Chopped meats."

During an interview on 9/19/18, the qualified intellectual disabilities professional (QIDP) confirmed client #4's diet is a chopped consistency. Further interview revealed client #4's meatloaf should have been in "bite sized" pieces.