DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED		
	34G246		B. WING			9/26/2018		
NAME OF PROVIDER OR SUPPLIER KENWOOD DRIVE HOME				STREET ADDRESS, CITY, STATE, ZIR 5004 KENWOOD DRIVE DURHAM, NC 27712				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
W 261	D DRIVE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure community representatives for it's specially constituted committee attended and participated in regular meetings. The finding is: Impartial human right's committee (HRC) members did not attend regular meetings. Review on 9/26/18 of the facility's HRC minutes revealed the following attendance by community representatives committee members: 8/29/17 - No community representative present 1/31/18 - No community representative present 7/12/18 - No community representative present During an interview on 9/25/18, the qualified intellectual disabilities professional (QIDP) confirmed their HRC did not have an impartial committee member and the company was		W 26					
W 382	CFR(s): 483.460(l)(2)	ID RECORDKEEPING	W 38	32		(X6) DATE		

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/27/2018 // APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
34G2		34G246	B. WING			_	09/26/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
KENWOO	D DRIVE HOME				004 KENWOOD DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 382	2 Continued From page 1 The facility must keep all drugs and biologicals locked except when being prepared for administration.		w	382				
	Based on observation	not met as evidenced by: ns and interviews, the facility edications remained locked.						
	The medications were left unsecured and unsupervised by the medication technician. During morning medication administration observations in the home on 9/26/18 at 7:15am, the medication technician exited the medication room, to flush a pill which had been dropped on the floor. Further observations revealed the surveyor remained in the medication room with five bubble packs of pills; which were laid on the table.							
	technician confirmed have been left unatter technician indicated h	e had training to ensure that be kept locked up, except						
	administration training revealed, "22. Mair during medication ad	tain security of medications ninistration - ensuring is locked when Medication						
	During an interview of intellectual disabilities	n 9/26/18, the qualified professional (QIDP)						

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		B. WING	09/26/2018				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		E		
KENWOOD DRIVE HOME				04 KENWOOD DRIVE URHAM, NC 27712			
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
W 382	Continued From page 2 confirmed all medications should be secured all		W 382				
W 460	times when not being administered. FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)		W 460				
	Each client must rece well-balanced diet ind specially-prescribed o	cluding modified and					
	Based on observatio interviews, the facility received a continuous consisting of needed identified in the indivi	not met as evidenced by: ns, record reviews and failed to ensure each client s active treatment plan interventions and services dual program plan (IPP) in s affected 1 of 3 audit clients					
	Client #4's diet was n	ot followed.					
	0	ations in the home on nner consisted of three and a pear.					
	Review of the menu f tortillas/taco shells."	or 9/25/18 revealed, "Two					
		client #4's IPP dated conds of vegetables only."					
	note dated 7/16/18 re	client #4's annual nutrition evealed, "[Client #4] is egetables only, as we are weight gain."					
		n 9/25/18, the qualified s professional (QIDP)					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/27/2018 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	34G246		B. WING			09/26/2018	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
KENWOO	D DRIVE HOME				5004 KENWOOD DRIVE DURHAM, NC 27712		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 460	confirmed client #4 sh	nould not have consumed ould have been prompted to	W	460			

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