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

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KEYWEST CENTER	1722 ATHENS AVENUE DURHAM, NC 27707

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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	The Keywest Center has an emergency preparedness plan. This plan will be reviewed and updated at least annually. The emergency plan includes a documented facility based and community based risk assessment, utilizing all hazards approach including missing clients. RECEIVED OCT 18 2018 DHSR-MH Licensure Sect	10-31-18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gwendolyn Y. Johnson	Administrative QIDP	10-18-18

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	The facility currently has in place an emergency plan based upon risk assessments.	10-31-18
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	The Facility has developed disaster emergency preparedness policies and procedures; and will currently execute such policies and procedures in the event of a disaster. The disaster policies and procedures will be reviewed and updated at least annually.	10-31-18

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E 013	Continued From page 2 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.	E 013		
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 [(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.	E 032	The facility's emergency preparedness plan includes a communication plan. A contact resource form has been developed. This form will list staff and community information to access during a disaster. Agencies such as the Red Cross Shelters, Emergency Operations Center, Civic Groups, Food Bank and the local Radio/TV Stations who broadcast pertinent information shall be included on this contact form. The facility has put in place an alternate means of communicating with staff and others during a disaster. A backup cell phone is included in the disaster preparedness kit.	10-31-18

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E 036	Continued From page 4 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	An emergency preparedness training and testing curriculum has been developed. This curriculum will be reviewed and updated at least annually. To ensure an understand of the facility's disaster emergency preparedness plan, staff will receive training and testing annually.	10-31-18
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	This has been an established procedure since the implementation of the HCPR process. In previous cases, we have a record of compliance within the HCPR guidelines; the process dictates Step #1 submit 24-hour initial report and Step#2 submit final 5-day working report. We will continue to follow the process when an actual incident occurs. The allegation for which the facility was cited came to our attention from the State Compliant department. During the time period of which the alleged incident occurred, we were unaware, and there was no evidence of any incidents of neglect, injury or abuse.	9/18/18

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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	This has been an established procedure since the implementation of the HCPR process. In previous cases, we have a record of compliance within the HCPR guidelines; the process dictates Step #1 submit 24-hour initial report and Step#2 submit final 5-day working report. We will continue to follow the process when an actual incident occurs. The allegation for which the facility was cited came to our attention from the State Compliant department. During the time period of which the alleged incident occurred, we were unaware, and there was no evidence of any incidents of neglect, injury or abuse. The Administrative QIDP nor the Administrator were present in the facility at the time of the assumed incident. On site at the time period of the alleged incident was the QIDP Supervisor and two (2) staff personnel. These employees reported a whole in the wall. As the client was under the supervision of the new employee. The client has a documented record of unpredictable falling and hurling himself backwards during behavioral outbursts. This apparent act resulted in a hole in the wall.	

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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	There was no witness to the occurrence except the new trainee. She had been advised to seek assistance if such behavioral outburst occurred that required additional staff intervention. The new employee did not make this request of the staff and nor did she indicate that the client was injured to supervisor present. The senior staff employee followed facility guidelines by submitting an incident/ injury/accident report. This report was filed and is maintain until further need arises. Therefore, no justification for step #1 and Step #2 of the HCPR protocol was viewed as necessary. Within a matter of days, the new employee did not return to work as scheduled, nor give notice of termination following the disclosure of 24-hour camera surveillance in common areas of the facility for client safety and protection. Despite my absence from the facility during the time period of the alleged incident, I the Administrative QIDP became the target of the allegation and the allegation remains unjustified. The alleged incident continues to be in question for the HCPR. This incident (hole in wall) did not meet the classic criteria for reporting to the HCPR. No neglect, no abuse, no injury or mistreatment can be substantiated. Keywest protocol for documenting any incident was followed through by staff.	9/18/18
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	A referral was made by the Primary Care Physician on August 17, 2018 to UNC Dental Clinic. No appointment has been scheduled to date (10-18-18). However, we continue to contact Amber (Coordinator) at the UNC Dental clinic for ongoing status and update. We have also contacted Murdoch Dental clinic (10-15-18) to make a referral for dental services. We are currently waiting to hear from Elizabeth Hayes of Murdoch regarding our referral for Client #1. No other information is available as of to date (10-18-18).	8-17-18 10-15-18

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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	Keywest continues to provide nourishing and well-balanced diet developed by a certified dietary specialist that are modified and specifically-prescribed for all residents of Keywest. The citation appears to be a broad generalization of this client's dietary needs. Client #4's diet is individualized, specific and detailed to include specific textures of individual food items. Client's visual and chewing dietary limitations require specificity. This includes, pacing, overloading and scooping of altered food. For the record, Client #4's diet consistency has always been prescribed as blenderized. Client #4 continues to receive a diet consistency of blenderization. Special consideration-modification can be made to her diet. She may require multiply food textures that can be altered (chopped, mashed, and crumbled). Meats such as chicken, beef or pork should be blenderized. Soft meats such as tuna, meatloaf, soft baked fish can be finely chopped and require no blenderization. Client #4, food alteration chart indicates, meatloaf may be finely chopped. Staff will continue to receive in-serving and impromptu training to ensure an understanding of food terminology, preparation and delivery of altered food modifications.	10-31-18

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W 460	Continued From page 9 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.	W 460		