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 _____	08/06/2019

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
W 000	INITIAL COMMENTS A recertficiation and complaint survey was completed on 8/6/19. No deficiencies were cited as a result of a complaint survey for Intake #NC00153181. However, deficiecies were cited during the recertification survey.	W 000		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the Individual Program Plan (IPP) for 1 of 3 audit clients (#3) included specific information to support their independence during dining. The findings are: 1. Client #3's IPP did not include specific interventions to support him while dining. During dinner and breakfast observations in the home on 8/5 - 8/6/19 at 6:28pm and 8:10am respectively, staff prepared client #3's food in the kitchen and brought it to him at the table. The client was not prompted or assisted to serve himself at the meals. At the dinner meal, client #3 was not prompted or assisted to wear a clothing protector and a large amount of spillage was noted on the table and the floor during the meal. At the breakfast meal, the client was provided with a clothing protector. Prior to eating, the client was consistently prompted to drink his liquids before being allowed to eat. For example, at the	W 240	The facility will ensure that all clients IPP support individuals independence. Client #3's IPP is current effective 8/24/2019. The IPP provides specific teaching strategies to support individual dining opportunities. Client will be monitored with staff guidance during dining. DHSR - Mental Health SEP 12 2019 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Gwendolyn Johnson, QIDDP/ Administrator 9/9/19

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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W 240	Continued From page 1 dinner meal, Staff C stated, "Would you like to drink your water [Client #3] so you can get your food?", "Drink your water so you can eat.", "You have to drink your water so you can get your food." Client #3 drank two of his three drinks before his food was provided. Additional observations of both meals revealed the Qualified Intellectual Disabilities Professional (QIDP) (at dinner) and the Administrator (at breakfast) provided verbal prompts for client #3 to "Slow down" or "Take a break." Further observations of both meals revealed client #3's right hand/wrist was periodically held down and restricted from movement while vesting. Review on 8/5/19 of client #3's IPP dated 8/25/19 and nutritional evaluation dated 8/13/18 revealed the client consumes a chopped diet, has limited chewing skills and should be monitored for his pace of eating at meals. Additional review of the IPP did not include specific information regarding his use of a clothing protector or assistance needed from staff to support him while eating. Interview on 8/6/19 with the Administrator revealed client #3 is prompted to drink before eating to give him a feeling of fullness so he won't attempt to consume his food so quickly. Additional interview noted the client's hand is held during the meal to slow his rate of eating and he usually wears a clothing protector to address his excessive spillage. The Administrator confirmed client #3's IPP did not include specific interventions to address his needs while dining.	W 240	Water will be offered at the start of meals with a wait time of 1 to 3 minutes, before offering solid foods. Gentle touch of client's hand for 5 seconds will be used to encourage client to decrease pace of eating. Staff will provide verbal prompts throughout the meal. For example, "slow down eating". If client displays episodes of eating to fast or overloading mouth, the process of gently touching client #3 hand will be repeated. Client #3 was reassessed by the nutritionist for family style participation. At this time, client #3 is not appropriate for family style dining due to the need of minimizing anxiety, food safety, and to protect other client's rights while dining. In addition, to the food looting behaviors and grabbing other client's food at the dining table, these behaviors are distracting to other clients. The IPP provides specific teaching strategies to support individual dining opportunities. All clients will be monitored with staff guidance during dining to promote independence while dining.	
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria	W 252		

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W 252	Continued From page 2 specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure data relative to the accomplishment of specified objective criteria was documented in measurable terms. This affected 1 of 3 audit clients (#3). The finding is: Client #3's objective data was not documented in measurable terms. A. During lunch observations at the day program on 8/5/19 at 11:44am and 11:54am, client #3 grabbed at food items belonging to two other clients at the table. During evening observations in the home on 8/5/19 at 5:56pm, client #3 became non-compliant while being prompted back to the living room. During the behavior, the client dropped down towards the floor. Interview on 8/6/19 with Staff A revealed all client behaviors are documented each day and days without behaviors are also recognized through the use of a calendar and stickers. Review on 8/5/19 of client #3's Behavior Intervention Plan (BIP) dated 2/28/18 revealed an objective to address target behaviors of physically acting out and non-compliance. The BIP identified food grabbing and dropping to the floor under the description for physically acting out	W 252	All clients BIP's and IPP's have been updated and are current. Clients current IPP's were reviewed to address all BIP's. BIP's are found in the individualized BIP Book of each client. Each individual program has in their possession copies of each individuals plan, goals, and data collection sheets. However, a new data sheet has been revised to show tracking of food grabbing and falling to the floor which is included in client #3 behavior improvement plan. The plan identifies specific target behaviors. Staff will receive in-service training to ensure all clients BIP's are being implemented and documented by 9-30-19. Client #3 BIP does include food grabbing and dropping to the floor. The data sheet is a form that describes target behaviors. Examples are given including etcetera.	

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W 252	Continued From page 3 behaviors. The plan also noted, "Recording procedures to record physical acting out and non-compliance is a part of data keeping process which enables us to evaluate this BIP and [Client #3's] functioning." Further review on 8/6/19 of the client's BIP data collection sheets did not include documentation of food grabbing or dropping to the floor behaviors exhibited on 8/5/19. Interview on 8/6/19 with the Administrator confirmed staff should be documenting client #3's target behaviors as indicated. B. Review on 8/6/19 of client #3's IPP dated 8/25/18 revealed objectives to identify a beverage with 100% accuracy for 7 consecutive days, to have no day time toileting accidents with 100% compliance for 5 consecutive days, to follow simple directions with 100% compliance for 5 out of 5 days, to go to and from TLC with 100% compliance for 5 out of 5 consecutive weeks and to go to and from Meals on Wheels with 100% compliance for 5 out of 5 consecutive weeks. Additional review of data collection sheets for each of the objectives revealed no data had been documented from 7/29/19 - 8/5/19. Interview on 8/6/19 with the Administrator and Qualified Intellectual Disabilities Professional (QIDP) indicated client #3 had been sick for several days during which his programming was suspended; however, objective training resumed on 7/29/19 and data should have been collected from this date forward.	W 252		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i)	W 255		

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W 255	Continued From page 4 The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the Individual Program Plan (IPP) for 2 of 3 audit clients (#4, #5) was revised after they had successfully completed an objective. The findings are: 1. Client #5's IPP was not revised after she had completed her Behavior Intervention Plan (BIP) objective. Review on 8/5/19 of client #5's BIP (dated 3/31/13) revealed target behaviors of physical aggression, verbal aggression and non-compliance while her Human Rights Committee (HRC) review sheets (9/28/18 - 6/2/19) noted an objective to receive daily verbal reinforcement at bedtime each day she avoids BIP episodes and a tangible reinforce such as a favorite drink each time she completes 7 consecutive days without a BIP episode. Additional review of the HRC review sheets also indicated client #5 had zero behavior episodes from June '18 - May '19. During an interview on 8/6/19, the Administrator acknowledged client #5 has had very few behaviors as identified in her 3/31/13 BIP and most of her behaviors are believed to be related to her emerging dementia symptoms. The Administrator confirmed the plan needed to be revised.	W 255	The facility has a monitoring system in place that provides weekly and monthly monitoring. Through this process all disciplines and non-professional programming will be re-assessed. All clients individual programs will also be monitored at least quarterly by the QIDDP and will be revised as necessary. This process allows for oversight and revisions which will be documented through the addendum process. THE PLAN 1. A Core Team meeting will take place to review, amend, and implement behavioral interventions and objectives. 2. Addendum's will be added as needed.	

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W 255	Continued From page 5 2. Client #4's IPP was not revised after she had completed her BIP objective. Review on 8/5/19 of client #4's BIP (dated 2015) revealed target behaviors of physical aggression, verbal aggression and non-compliance while her Human Rights Committee (HRC) review sheets (6/1/18- 5/31/19) noted an objective to receive daily verbal reinforcement and gentle shoulder pat each day she avoids BIP behaviors and tangible reinforcers such as trip to mall or special treat each time she completes 7 days without BIP episode. Additional review of the HRC review sheets also indicated client #4 had zero behavior episodes from June '18 - May '19. During an interview on 8/6/19, the Administrator acknowledged that over the past year, client #4 had not exhibited any behaviors identified in her BIP. She stated that client #4 had frequent outburst that disrupts the other clients in the home. Administrator confirmed the plan needed to be revised to reflect her current behaviors.	W 255		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		

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W 263	Continued From page 6 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure written informed consent was obtained from client #3's guardian for his restrictive Behavior Intervention Plan (BIP). This affected 1 of 3 audit clients. The finding is: A current written informed consent was not provided for client #3. Review on 8/5/19 of client #3's BIP dated 2/28/18 revealed an objective to address his physically acting out behaviors and non-compliance. The plan also incorporated the use of Abilify, Trazadone, Melatonin and Citalopam. Additional review of the client's record indicated the last written informed consent for his BIP was obtained in 2017. Interview on 8/6/19 with the Administrator confirmed no current written informed consent for the BIP had been obtained from client #3's guardian.	W 263	The Committee will continue to ensure that all programs are conducted only with the written informed consent of the clients, parents, or legal guardian. During the time of review consents were unable to be located. However, client #3 consent forms were located and secured. The dates reflect October 1, 2018. The Facility was compliant at the time of review.	
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure client #3 and #4 ate in a manner which was not stigmatizing. This affected 2 of 3 audit clients. The finding is: Client #3 was not assisted to eat in the least	W 488	The facility will ensure that each client eats in a manner consistent with his or her developmental level. Clients #3 and #4 will not utilize clothing protectors positioned under their plates during mealtime. The facility will ensure each client is assited in the least stigmatizing manner possible.	

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W 488	Continued From page 7 stigmatizing manner. During breakfast observations in the home on 8/6/19 at 8:14am, client #3 consumed his meal with the upper portion of his clothing protector secured around his neck and the lower portion positioned underneath his plate. The client consumed his food with his clothing protector positioned in this manner while a staff assisted him at the meal. Review of client #3's Individual Program Plan (IPP) dated 8/25/18 revealed the client consumes his food with his choice of eating utensils. Additional review of the plan did not include any information regarding the use of a clothing protector. Interview on 8/6/19 with the Administrator confirmed client #3's clothing protector should not have been worn as described. 2. Client #4 was not assisted to eat in the least stigmatizing manner possible. During lunch and breakfast observations in the home on 8/5/19 at 11:11am and 8/6/19 at 8:14am, staff applied a large cloth clothing protector around client #4's neck. Client #4 consumed her meal in this manner with minimal spillage noted. Review of client #4's IPP dated 8/6/19 revealed client #4 consumes her food independently however staff monitor to help reduce overloading	W 488		

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W 488	Continued From page 8 of spoon/decrease pace of eating. Additional review of the plan did not include any information regarding the use of a clothing protector. Interview on 8/6/19 with the Administrator revealed they use the clothing protectors to protect the clients clothing and to make them feel comfortable. She confirmed the clothing protector was not discussed in client #4's IPP.	W 488		

KEYWEST CENTER, INC.

1722 Athens Avenue
Durham, NC 27707
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TONY BULLOCK
Administrator

GWENDOLYN JOHNSON
QIDDP/Administrator

September 9, 2019

Ms. Wilma Worsley-Diggs, M.Ed., QIDP
Facility Compliance Consultant I
Mental Health Licensure and Certification Section
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Recertification and Complaint Survey

Dear Ms. Wilma Worsley-Diggs:

Enclosed is the written plan of correction for the Keywest Center regarding deficiencies cited during the recertification and complain survey conducted August 5-6, 2019.

Please call our office if you have any questions, or should you need further clarification concerning the facility's 2019 corrective action plan.

Sincerely,

Gwendolyn Johnson, QIDDP/Administrator
Gwendolyn Johnson
QIDDP/Administrator