	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[Grab your reader's attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]	34G246	A. BUILDING _____ B. WING _____	11/13/2019
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the content of each individual's Restrictive Program/Behavioral Medication Review was accurate for 1 of 3 audit clients (#3). The finding is: Client #3's individual program plan (IPP), contained inaccurate information. Record review on 11/13/19 of client #3's IPP revealed it was complete on 5/22/18 then closed with a single line and hand written 5/22/19. Further review revealed annual physical was completed 2/2/18 and medication review was last complete on 4/9/18. Additional review of the record revealed the latest annual physical was completed on 2/6/19 and last medication review was completed 4/8/19. Interview on 9/4/19 with the qualified intellectual disabilities professional (QIDP) revealed the information was inaccurate in the IPP.	W 111	W111 A review of systems revealed that ASI policies and procedures regarding IPP's was not adhered to for client #3 in that the dates on the IPP were inaccurate and did not reflect the current year's review data and information. To correct the deficiency IPP's will be reviewed and revised annually or more often if necessary and will reflect the accurate information from members of ASI interdisciplinary team as information is made available to the QP. Additionally, the QP will be re-trained on how to accurately complete an IPP to reflect current and accurate data. To prevent this problem from occurring again, the Program Director will monitor the IPP's within 10 days of the interdisciplinary team IPP meeting to ensure that the IPP's reflect the current and accurate data and will report any discrepancies to the Executive Director for further action if necessary. Items listed above will be completed within 30 days after the approval of the plan of correction.	
W 248	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.	W 248	RECEIVED DEC 02 2019 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	11-26-19

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 248	Continued From page 1 This STANDARD is not met as evidenced by: Based on reviews and interviews the facility failed to assure outside services meet the needs of each client. This affected 1 of 3 audit clients (#3). The finding is: Clients #3 did not have current individual program plans (IPP) and current behavior intervention plan (BIP) available to at the day program. During review on 11/12/19 at the day program of client #3's record revealed an individual program plan (IPP) dated 5/22/18 and BIP dated 4/1/17. This was the most current IPP and BIP on file at the day program. Review on 11/13/19 of client #4's record at the office revealed an IPP dated 5/22/19 and BIP dated 4/1/19. This was the most current IPP, BIP on file at the office During an interview on 11/13/19, the qualified intellectual disabilities professional (QIDP) confirmed they thought the day program had the client's current IPP's and BIP's available at the day program.	W 248	W248 A review of ASI systems revealed that although there was a current BIP, it was not provided to the client's day program and that the information on the IPP provided to the day program was inaccurate and outdated in keeping in line with ASI's policy and procedures regarding both the IPP and the BIP. To correct this deficiency, the QP will be re-trained on the importance of providing both accurate and complete IPP and BIP data to the day program and other outside entities. To prevent this problem from occurring again, the Program Director will monitor the activities of the QP on a quarterly basis to assure an accurate, complete, and current IPP and BIP has been provided to the Day Program by the QP. The Program Director will escalate any issues of non-compliance to the Executive Director should strict adherence to ASI policy and procedures regarding IPP's and BIP's not be adhered to. Items listed above will be completed within 30 days after the plan of correction is approved.	
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.	W 288		

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W 288	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review and confirmed with interview, the facility failed to assure all techniques to manage behavior were incorporated into an active treatment program. This affected 1 of 3 audit clients (#4). The finding is: Client #4's use of Psychotropic medication for behavior control was not incorporated into an active treatment plan. Review on 11/13/19/19 of client #4's physician's orders dated 6/1//19 revealed he is the following; Klonopin, Naltrexone, Depakote, Seroquel, Propanolol and Ingrezza prescribed for behavior management. Review on 11/13/19 of Client #4's active treatment plan revealed a behavior support plan (BSP) implemented 8/12/19. Further reviewed of the BSP revealed no medication prescribed for behavior management. Interview on 11/13/19 with the qualified intellectual disabilities professional (QIDP) confirmed client #4 receives Klonopin, Naltrexone, Depakote, Seroquel, Propanolol and Ingrezza behavior management. She further acknowledge the medication should be included in the BSP	W 288	W288 – A review of systems at ASI revealed that the client to which the deficiency mentioned (client #4) has been discharged from ASI, however, to correct this issue and to prevent it from occurring with other clients, ASI will strictly adhere to its policies and procedures regarding psychotropic medications. The psychologist responsible for developing the BSP's will be retrained on how to include all medications, especially psychotropic medications, on the BSP according to the physician's orders. To correct this deficiency and to assure this is an isolated incidence and not a systemic issue, the QP will conduct a review of ASI BSP's to assure that the medications are included on the BSP's for other clients. During the scheduled CRC meeting, the QP will monitor the BSP's to assure that these medications are included on the BSP's. Items listed above will be implemented within 30 days after the plan of correction is approved.	
W 313	DRUG USAGE CFR(s): 483.450(e)(3) Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.	W 313		

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W 313	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a drug used for the control of client #3's inappropriate behavior was used only after the potentially harmful effect of the behaviors outweigh the harmful effect of the drug. This affected 1 of 4 audit clients. The finding is: Client #3's behavior data did not support the use of psychotropic medication. Review on 11/13/19 of client #3's record revealed a behavior support plan (BSP) the client to exhibit zero (0) challenging behavior per month for twelve (12) consecutive months. Additional review of client #3's current physician's orders dated 8/14/19 indicated an order for Risperdal prescribed for behavior. Further review of monthly progress notes from January '18 - July'19 revealed the client had exhibited 0 targeted behaviors. Additional review of the record did not indicate the interdisciplinary team had discussed the continued use of the drug in relation to client #3's behavior data. Interview on 11/13/19 with the program coordinator and qualified intellectual disabilities professional (QIDP) confirmed the team had not discussed client #3's continued use of psychotropic medication in relation to the lack of significant behaviors over 2 years.	W 313	W313 A review of systems revealed on client #3, his bizarre and unusual behaviors had been stable and non-occurring for several years. Upon further review and in communications with both ASI's nurse and our Psychiatrist, in 2014, a reduction in medication precipitated bizarre and unusual behaviors in client #3. ASI's nurse noted that in every quarterly drug review, the psychiatrist and the nurse did discuss the possibility of reducing the Risperdal because client #3 was not displaying any bizarre or unusual behaviors, and had not been since 2014. However, the continued use of Risperdal for Client #3 was not discussed in the IDT meeting. To correct this issue, the IDT with input from both the psychiatrist and the nurse will discuss individuals on psychotropic drugs, review their behavior data and decide if the meds can be attempted to reduced or not. The QP and Nurse will be re-trained on the necessity of communicating between the disciplines especially regarding use of psychotropic drugs. To prevent this from occurring again, the CRC chair will monitor the discussions of usage of psychotropic drugs and assure that input from the physician is obtained to be discussed in the CRC meetings on a quarterly basis. These issues will be corrected within 30 days of approval of this plan of correction.	
W 325	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(iii) The facility must provide or obtain annual physical	W 325		

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W 325	Continued From page 4 examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure lab work was obtained as ordered by the physician for 2 of 3 audit clients (#2, #3). The findings are: a. Lab work for client #3 was not obtained as ordered. Review on 11/13/19 of client #3's current physician's order revealed the following: CBC w/Diff, CMP, A1C, Lipid Panel every 6 months. Additional review of client #3's current record revealed the most recent labs dated 2/9/19. During an interview on 11/13/19, the qualified intellectual disabilities professional (QIDP) confirmed client #3's record did not have any more recent labs. b. Review of client #2's record on 11/13/19 revealed a physician's order dated 6/2/19 for a six months period. The physician's order listed client #2's current medications and a statement that said "Labs every six months, CBC w/Diff, CMP, Alc, and lipid panels." Further review of client #2's record revealed the last labs were collected on 8/22/18. Interview on 11/13/19 with the QIDP and program coordinator revealed that labs have been collected since 8/22/18, but no paperwork could be provided to support this. The QIDP confirmed that it appears that the last labs were collected on	W 325	W325 A review of systems revealed that labs that had been ordered from the physician had not been completed in a timely manner. ASI has an electronic health record that should be utilized to assure that appointments are kept. In addition, ASI utilizes a paper appointment tracking system that is kept in the front of the medical records. To correct this issue, the RN and lead staff will be re-trained on the use of THERAP, our electronic health record, as well as how to use the paper appointment tracking system. To prevent this from occurring again the RN will monitor appointments scheduled on/ in the tracking system to ensure appointments are met on a monthly basis. When labs are returned, they will be filed and entered into THERAP by the RN or her designee such as the lead staff. Additionally, the Program Director will assist the RN with the monitoring of Lead Staff to ensure appointments are met during the designated time listed in the approved tracking system on a monthly basis. The tracking system will be displayed in the front of each medical record book for easy access and review. Items listed above will be completed within 30 days of approval of plan of correction.	

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W 325	Continued From page 5 8/22/18.	W 325	A review of systems revealed that dental appointments had been set up, however, the lead staff failed to take the clients to their appointments. To correct this issue, the lead staff will be retrained in the importance of assuring all dental appointments are kept. Additionally, dental appointments should be placed in THERAP and in our paper appointment tracking system as well. To prevent this from occurring again, the QP will monitor the dental appointments to assure that the lead staff are following up with the appointments and documenting them in THERAP and on the paper appointment tracking system on a monthly basis. This paper system will be displayed in the front of each medical record book for easy access and review. Items listed above will be completed within 30 days of approval of plan of correction.	
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 review and interview the facility failed to assure 1 of 3 audit clients (#4) was provided a dental examination no later than one month after admission to the facility. The finding is: Client #4 did not receive a dental examination in a timely manner. Review on 11/13/19 of client #4's record revealed he was admitted into the facility on 10/18/18. Further review revealed no dental examination performed as of 11/13/19. This assessment was not performed within 30 days of his admission. During an interview on 11/13/19, the qualified intellectual disabilities professional (QIDP) confirmed client #4's dental examination have not been completed since his admission.	W 351		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)	W 460		

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W 460	Continued From page 6 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 1 of 3 audit clients (#2) received his specially-prescribed diet as indicated. The finding is: Client #2's diet was not followed. During observations at the day program on 11/12/19 at 11:58am, client #2 was eating his lunch. He had a diet soda, sandwich with meat and lettuce, bag of potato chips, pudding, apple sauce, and oatmeal creme pie. Review of client #2's individual program plan (IPP), dated 1/15/19, revealed that client #2 is on a heart healthy diet, low in fat, cholesterol and sodium and high in fiber. Interview on 11/12/19 with the day program manager revealed that client #2 is not on a special diet. The day program manager revealed that he brings a variety of lunches to eat, sometimes a sandwich, and always two snacks, usually chips and some type of sweets, for the designated break times. However, he usually eats both his snacks with his lunch. Interview on 11/13/19 with the program coordinator revealed that client #2's is on a heart healthy diet. The program coordinator stated that because he is on this special type of diet, he should not be consuming chips and sweets daily for his snacks but should be eating healthier	W 460	W460 A review of systems revealed that the menu was not followed for specific diets. To correct this issue, the Dietitian will revise the menu to reflect a clear and precise break down of everyone's dietary needs of the home, and the lead staff and staff will be retrained on the importance of assuring clients have the correct diets. To prevent this deficiency from occurring again, the QP will monitor the meals prepared by the lead staff and other staff on a monthly basis to assure that diets are be adhered to. Additionally, ASI's Dietitian will complete monthly observations of meals to ensure the menu is followed by staff. Items listed above will be completed within 30 days of approval of plan of correction.	

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W 460	Continued From page 7 options.	W 460		