

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual and complaint survey was completed on March 12, 2020. The complaints were substantiated (Intake #NC00161647 and #NC00161765). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 109	<p>27G .0203 Privileging/Training Professionals</p> <p><b>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS</b></p> <p>(a) There shall be no privileging requirements for qualified professionals or associate professionals.</p> <p>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(d) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> <li>(1) technical knowledge;</li> <li>(2) cultural awareness;</li> <li>(3) analytical skills;</li> <li>(4) decision-making;</li> <li>(5) interpersonal skills;</li> <li>(6) communication skills; and</li> <li>(7) clinical skills.</li> </ol> <p>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.</p> <p>(f) The governing body for each facility shall develop and implement policies and procedures</p>	V 109		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 109	<p>Continued From page 1</p> <p>for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 Former Qualified Professional (FQP) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:</p> <p>Review on 03/11/2020 of the QP's record revealed: -A hire date of January 2020. -A job description of QP. -Master of Fine Arts and Bachelor's Degree of Arts. -Termination date of 03/06/2020.</p> <p>Review on 03/11/2020 of Deceased Client (DC) #1's record revealed: -Admission date 11/21/19. - Deceased date 02/29/2020. -Diagnoses of Severe Intellectual Developmental Disability, Autism and Cerebral Palsy.</p> <p>Review on 03/11/2020 of a North Carolina Incident Response Improvement System (IRIS) dated 02/29/2020 revealed: "-Consumer (DC#1) was taken to his primary physician due to having a fever. Physician recommended he go straight to the emergency room. Consumer was admitted after tests were</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 109	<p>Continued From page 2</p> <p>run that showed he may have pneumonia. Staff regularly visited consumer while he was in the care of the hospital. After roughly two weeks, consumer passed away from complications due to pneumonia."</p> <p>Review on 03/11/2020 of the facility's General Event Reports dated 02/10/2020 revealed: "[DC #1] was taken to his primary physician because he had a reported low-grade fever, cough and pale skin."</p> <p>Review on 03/12/2020 of a Performance Improvement Plan (PIP) for the FQP revealed: -Date Initiated: 03/06/2020 -Identify Areas Needing Improvement: Other-Violation of 5-1 Workplace Conduct #22 Unsatisfactory job performance -Specific examples to support request for improvement: 1. Failed to notify guardian, in a timely manner, when member fell and broke his nose. 2. Failed to notify mother, when member was admitted into the hospital. 3. Sent member to day program after mother asked for member to stay home, due to him not feeling well. 4. Failed to notify guardian that member stayed home from day program, due to being sick. -Terminated: 03/06/2020 -Written statement on the back of termination paper completed by the Former QP: In my defense, I just started QPing and I was unaware of what proper procedures went into and under what circumstances I was to contact parents. I did notify [DC #1's] mom when he went to the hospital, she and I spoke at length about what to do after he was x-rayed because they were needing to treat him for pneumonia. I contacted [consumer] mother a day later after I learned he had broken his nose,. I did not know I needed to contact [Client #1's]</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 109	<p>Continued From page 3</p> <p>guardian because she was staying home as precautionary when she was having bowel issues.</p> <p>I was not informed that [Client #2's] mom wanted him to stay home until after he was taken to [Day Program], so I don't think that was my fault."</p> <p>During interview on 03/12/2020 staff #3 revealed:</p> <ul style="list-style-type: none"> <li>-DC #1 went home on 02/07/2020 and came back to the facility on 02/10/2020 that evening.</li> <li>-She returned to the facility on Tuesday 02/11/2020 for the 7:00am shift.</li> <li>-DC #1 mother's had called her Sunday (02/09/2020) and reported DC #1 had a fever and she was keeping him till Monday and had given him cough syrup.</li> <li>-She took DC #1's temperature and it was 100.5 and she called the FQP and he informed her if the temperature got worse then they would take him to the doctor.</li> <li>-FQP told her to take DC #1 to the Day Program.</li> <li>-She felt like the FQP should have called and made an appointment.</li> <li>-The FQP called her back later and told her DC #1 was on his way back to the facility and a doctor appointment had been made for DC #1.</li> <li>-She continued to monitor DC #1 until his appointment at 3:00pm that afternoon.</li> <li>-The agency nurse asked her who told her to send DC #1 to the Day Program with a fever and she informed her that the FQP told her to send him to the day program.</li> </ul> <p>During interview on 03/12/2020 staff #5 revealed:</p> <ul style="list-style-type: none"> <li>-She worked the night shift from 11:00pm to 7:00am.</li> <li>-DC #1 was coughing and hot and sweaty throughout the night.</li> <li>-She got DC #1 up and got him dressed and fed and the morning staff (Staff # 3) came in at</li> </ul>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 109	<p>Continued From page 4</p> <p>7:00am and we checked his temperature. -Staff #3 called the FQP to let him know of DC #1 having a fever but she did not know what he told staff #3.</p> <p>During interview on 03/12/2020 the agency Registered Nurse (RN) revealed: -She was the nurse for the Day Program and the Residential homes. -DC #1 went home on 02/07/2020 and returned on 02/10/2020 in the evening. -The mother of DC #1 told staff she had kept DC #1 longer because he had a fever and was coughing. -She was in her office on 02/11/2020 at the Day Program and she saw FQP walk in with the Kenwood House clients and DC #1 was with them. -She had told the FQP and the staff at the facility to not bring DC #1 to the Day Program because he had a fever. -She checked DC #1's fever and it was 100.4 and she told FQP to take DC #1 home immediately and a doctor's appointment was going to be made. -She asked the FQP why did he bring him and the FQP told her he only had a low grade fever. -She called the doctor's office immediately and made the earliest appointment available which was at 3:00pm. -DC #1 was taken to the doctor and was immediately sent by ambulance to the Emergency Room and 2 weeks later he passed away. -The FQP only responded with DC #1's fever was not that high when asked why he brought him to the day program.</p> <p>During interview on 03/12/2020 the FQP revealed:</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 109	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>-He had only been a QP at the facility since the end of January.</li> <li>-He was terminated from his position due to a lot of complaints from the facility.</li> <li>-DC #1 got sick over the weekend on a home visit and returned Monday evening to the facility.</li> <li>-A house provider called me Tuesday morning (02/11/2020) and asked me what to do because DC #1 had a fever.</li> <li>-He told the house provider to give him a PRN (as needed) medication for his fever and to send him to the Day Program.</li> <li>-The house provider took him to the Day Program and the nurse assessed him and sent him back home to rest.</li> <li>-A doctor's appointment was made at 3:00pm the same day for DC #1.</li> <li>-DC #1 went to the doctor's appointment and he was sent to the emergency room by ambulance.</li> <li>-He went to the emergency room and a x-ray had been completed and DC #1's lungs were filled with fluid.</li> <li>-When he sent DC #1 to the Day Program he only had a low grade fever and was not exhibiting any other symptoms except a slight cough.</li> </ul> <p>During interview on 03/11/2020 and 03/12/2020 the Program Director revealed:</p> <ul style="list-style-type: none"> <li>-The FQP was terminated due to making poor decisions.</li> <li>-She was not aware the FQP told staff at the facility to send DC #1 to the day program with a fever.</li> <li>-The protocol for all staff is if any client has a fever, diarrhea or throwing up they are not to attend the day program.</li> </ul> <p>Review on 03/12/2020 of the Plan of Protection dated 03/12/2020 and completed by the Program Director revealed:</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 109	<p>Continued From page 6</p> <p>"-What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -Send an scomm/email to all staff to notify them of general decision making skills. -Hab techs are to notify their QP for any medical concerns. QP will then notify Nurse and Program Director. Describe your plans to make sure the above happens. -Program Director will send scomm/email out by end of business day."</p> <p>The facility served adult clients ranging in ages from 42 to 54 year olds whose diagnoses included Autistic Disorder, Severe Intellectual Disability, Diabetes and Cerebral Palsy. DC #1 went on a home visit which began on February 7, 2020 and returning to the facility on the evening on February 10, 2020. While on the home visit DC #1 became sick with a fever and cough and the mother informed staff upon his return he had those symptoms. On February 11, 2020 the house staff informed the FQP that DC#1 continued to have a fever. The FQP instructed the staff to administer a PRN medication and send him to the Day Program. The DC #1 was sent home from the Day Program by the nurse and was sent to the doctor at 3:00pm the same day. The doctor sent DC #1 to the emergency room and DC#1 passed away at the hospital approximately two weeks later. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$1000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 118	Continued From page 7	V 118		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 118	<p>Continued From page 8</p> <p>facility failed to keep the MARs current affecting two of two audited clients (#1 and #2) and failed to ensure staff were trained by a registered nurse, pharmacist or other legally qualified person affecting four of four auditing staff (#1-#4). The findings are:</p> <p>Finding #1 Review on 03/11/2020 of client #1's record revealed: -54 year old female. -Admission date of 10/14/99. -Diagnoses of Intermittent Explosive Disorder, Severe Intellectually Developmental Disability, Hypothyroidism, Diabetes and Hyponatremia.</p> <p>Review on 03/11/2020 of client #1's Physician's orders revealed: 01/10/2020 -Carbamazepine (used to treat bipolar disorder) 200 milligram (mg) Take 1 tablet by mouth 3 times daily. 04/11/19 -Furosemide(used to treat fluid retention) 20mg Take one tablet every morning on Monday's for fluid. -Atorvastatin (used together with diet to lower blood levels of "bad" cholesterol) 20mg Take one tablet by mouth every night at bedtime.</p> <p>Review on 03/11/2020 of client #1's February and March 2020 MARs revealed: -No initials to indicate the medication had been administered -Carbamazepine 200mg-03/01/2020 at 8pm -Furosemide 20mg-Initials were on the MAR on 03/10/2020 and 03/11/2020 as being administered but she is only supposed to get the medication on Mondays. -Atorvastatin 20mg- 02/12/2020 at 8pm.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 118	<p>Continued From page 9</p> <p>Finding #2 Review on 03/11/2020 of client #2's record revealed: -42 year old male. -Admission date of 03/21/01. -Diagnoses of Autistic Disorder, Severe Intellectual Developmental Disability, Birth Anoxia, Cerebral Palsy with Spastic Quadraparesis.</p> <p>Review on 03/11/2020 of client #2's Physician's orders revealed: 09/10/19 -Lactulose (used to treat chronic constipation) 15 milliliters(ml) Take 30mls by mouth three times daily for bowel movements. -Daily Multi Vitamin-Iron (Vitamin Supplement) Take one tablet by mouth every morning. -Docusate Sodium (used to relieve occasional constipation) 100mg Take 1 capsule by mouth twice daily for bowels. -Linzess (used to treat chronic constipation) 290 mcg Take 1 capsule by mouth 30 minutes before breakfast every morning. -Loratadine (used to treat sneezing, runny nose, watery eyes, hives, skin rash, itching, and other cold or allergy symptoms) 10mg Take one tablet by mouth every morning. -Pravastatin Sodium 40mg Take one tablet by mouth every night at bedtime for cholesterol. 08/07/19 -Benzotropine (used together with other medicines to treat the symptoms of Parkinson's disease (muscle spasms, stiffness, tremors, poor muscle control)) Mes 1mg Take 1 tablet by mouth twice daily. -Clonazepam (treat seizures and certain types of anxiety disorders) 1mg Take 1 tablet by mouth twice daily.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 118	<p>Continued From page 10</p> <p>-Levetiracetam(used to treat partial onset seizures) 500mg Take one tablet by mouth twice daily.</p> <p>-Risperidone (used to treat schizophrenia) 0.5mg Take one tablet by mouth twice daily.</p> <p>-Topiramate 200mg (used to treat seizures) 200mg Take one tablet by mouth twice daily.</p> <p>Review on 03/11/2020 of client #2's February and March 2020 MARs revealed the following blanks:</p> <p>-Lactulose 30 mls- 01/17/2020-01/18/2020 at 8am, 01/26/2020 at 3pm, 02/02/2020 at 8pm, 02/07/2020 at 3pm and 8pm, 02/08/2020-02/09/2020 at 8am, 3pm and 8pm, 02/20/2020 at 8pm, 02/21/2020 at 8pm, 02/22/2020-02/23/2020 at 8am, 3pm and 8pm, 03/04/2020 at 8am.</p> <p>-Daily Multi Vitamin-Iron- 02/08/2020-02/09/2020 at 8am, 02/22/2020-02/23/2020 at 8am.</p> <p>-Docusate Sodium 100mg- 02/07/2020 at 8pm, 02/08/2020-02/09/2020 at 8am and 8pm, 02/20/2020 at 8pm, 02/21/2020 at 8pm, 02/22/2020-2/23/2020 at 8am and 8pm.</p> <p>-Linzess 290mcg-02/08/2020, 02/09/2020, 02/22/2020, 02/23/2020 at 6:30am.</p> <p>-Loratadine 10mg-02/08/2020, 02/09/2020, 02/22/2020, 02/23/2020 at 8am.</p> <p>-Pravastatin Sodium 40mg-02/07/2020-02/09/2020 at 8pm, 02/15/2020-02/16/2020 at 8pm, 02/20/2020-02/23/2020 at 8pm.</p> <p>-Benzotropine 1mg-02/07/2020 at 8pm, 02/08/2020-02/09/2020 at 8am and 8pm, 02/20/20 at 8pm, 02/21/2020 at 8pm, 02/22/2020-02/23/2020 at 8am and 8pm.</p> <p>-Clonazepam 1mg- 02/07/2020 at 8pm, 02/08/2020-02/09/2020 at 8am and 8pm, 02/20/2020 at 8pm, 02/21/2020 at 8pm, 02/22/2020-02/23/2020 at 8am and 8pm.</p> <p>-Levetiracetam 500mg-02/07/2020 at 8pm,</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 118	<p>Continued From page 11</p> <p>02/08/2020-02/09/2020 at 8am and 8pm, 02/20/2020 at 8pm, 02/21/2020 at 8pm, 02/22/2020-02/23/2020 at 8am and 8pm. -Risperidone 0.5mg-02/07/2020 at 8pm, 02/08/2020-02/09/2020 at 8am and 8pm, 02/20/2020 at 8am and 8pm, 02/21/2020 at 8pm, 02/22/2020-02/23/2020 at 8am and 8pm. -Topiramate 200mg-02/07/2020 at 8pm, 02/08/2020-02/09/2020 at 8am and 8pm, 02/20/2020 at 8am and 8pm, 02/21/2020 at 8pm, 02/22/2020-02/23/2020 at 8am and 8pm, 02/24/2020 at 8am.</p> <p>Finding #3 Review on 03/11/2020 of staff #1's record revealed: -Hire date of 12/04/19. -Habilitation Technician. -Medication Administration Competency Test dated 10/21/19 with only the staff's signature.</p> <p>Review on 03/11/2020 of staff #2's record revealed: -Hire date of 11/18/19. -Habilitation Technician. -Medication Administration Competency Test dated 11/18/19 with only staff's signature.</p> <p>Review on 03/11/2020 of staff #3's record revealed: -Hire date of 10/22/19. -Habilitation Technician. -Medication Administration Competency Test dated 10/22/19 with only staff's signature.</p> <p>Review on 03/11/2020 of staff #4's record revealed: -Hire date of 10/21/19. -Habilitation Technician. -Medication Administration Competency Test</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-204</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 KENWOOD DRIVE JACKSONVILLE, NC 28540</b>
--	--

(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) COMPLETE DATE
V 118	<p>Continued From page 12</p> <p>dated 10/21/19 with only staff's signature.</p> <p>During interview on 03/12/2020 staff #3 revealed: -When she worked for another facility staff were trained by a nurse. -Staff now are being trained by watching a module on the computer. -The nurse is not present and the computer module can be done from home or at the office.</p> <p>During interview on 03/12/2020 staff #4 revealed: -The training for medication administration was completed on a computer module. -No one is with you when you complete the training modules. -The training modules could be completed at home.</p> <p>During interview the Registered Nurse (RN) revealed: -The staff from each facility was supposed to send her a medication count each week. -Some staff are doing this and some are not. -A staff meeting was being held on 03/18/2020 to express the importance of the MARs and the correct documentation. -The medication administration training in done with a video. -Some staff need more training and some are ok with the video. -The video can be completed anytime and she was not present when staff completed the video.</p> <p>Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.</p>	V 118		