

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/19/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2021
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NAME OF PROVIDER OR SUPPLIER KENWOOD DRIVE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5004 KENWOOD DRIVE DURHAM, NC 27712
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(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
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W 130	<p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure client #2 was afforded privacy during personal care. This affected 1 of 6 audit clients. The finding is:</p> <p>During observations in the home on 1/12/21 at 7:32am, client #2 was observed in the shower. Staff D was bathing client #2 with the bathroom door open, and client #2 could be seen from the hallway in the reflection of the mirror standing in the shower. Further observations at 7:34am revealed client #2 standing in the middle of the bathroom, completely undressed, with Staff D using a towel to dry him off. During the time client #2 was in the bathroom, his peer was walking in and out of his bedroom that is located directly across the hall from the bathroom. At no time was client #2 prompted to close the bathroom door nor did staff close the door.</p> <p>Review on 1/12/21 of client #2's individual program plan (IPP) dated 4/5/20 did not reveal a strength or need in the area of closing the door for privacy.</p> <p>Additional review on 1/12/21 of client #2's record revealed an Activities of Daily Living Assessment dated 4/1/20. The Activities of Daily Living Assessment's area for closing the door for privacy was not completed in order to identify a strength or need in this area.</p>	W 130		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 130	Continued From page 1	W 130			
W 159	<p>Interview on 1/12/21 with the Qualified Intellectual Disabilities Professional (QIDP) and the Home Manager (HM) confirmed that staff should verbally prompt client #2 to close the door and if he doesn't, staff should close it.</p> <p>QIDP CFR(s): 483.430(a)</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to ensure the qualified intellectual disability professional (QIDP) coordinated, integrated and monitored active treatment for 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). The findings are:</p> <p>A. Review on 1/12/21, revealed that the facility failed to update the current individual program plan (IPP) for 5 of 6 audit clients (#1, #3, #4, #5 and #6).</p> <p>Interview on 1/11/21 with the QIDP revealed that she had current IPPs on a thumb drive that was located at her office and she would bring the updated IPP to the facility on 1/12/21. Additional interview on 1/12/21 with the QIDP revealed no updated IPP were available.</p> <p>B. Throughout the survey on 1/11/21 through 1/12/21, all clients in the home were observed to sit in the living room, sit in their bedrooms, and sit and/or lay on the couch in the activity room. During the observations, staff were observed to sit in the living room watching television or use</p>	W 159			

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W 159	<p>Continued From page 2</p> <p>their personal cell phones. There were minimum interactions from staff to prompt or encourage the clients to actively participate in any form of active treatment.</p> <p>Interview on 1/12/21 with the Home Manager (HM) revealed that he recently returned from a two month extended leave yesterday. The HM stated that typically, the QIDP is responsible for coordinating client services during the HM's absence. On 1/11/21, he discovered that activities for January had not been planned.</p> <p>C. Review on 1/12/21 of clients #1, #2, #3, #4, #5 and #6's data collections on their formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review.</p> <p>Interview on 1/12/21 with the QIDP revealed that she is sure staff are documenting data on training objectives and programs, and there must be a glitch in the system as to why no data is available. The QIDP confirmed that if no data is documented, it was not done</p> <p>D. Review on 1/12/21 revealed the facility failed to ensure the restrictive behavior techniques which included the use of psychotropic medication for 3 of 6 audit clients (#1, #2 and #6) was reviewed and monitored by the human rights committee (HRC).</p> <p>Interview on 1/12/21 with the Program Director (PD) revealed if no written review or consent by the HRC was available for review in client #1, #2 and #6's record, they were not obtained.</p> <p>E. Review on 1/12/21, revealed the facility failed</p>	W 159			

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W 159	Continued From page 3 to ensure written informed consent was obtained for clients restrictive Behavior Intervention Plans (BIP). This affected 3 of 6 audit clients (#1, #2 and #6). Interview on 1/12/21 with the QIDP confirmed that she had not obtained written consent for client #1, #2 and #6. Interview on 1/12/21 with the PD revealed that she had concerns that the QIDP was not spending sufficient time in the home, monitoring staff and client services. The PD acknowledged that if the QIDP was not able to produce documentation that IPP's, BIP's, HRC and guardian consents were done, as the QIDP indicated, then the work was likely incomplete.	W 159			
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The team failed to: ensure that each client received a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training and treatment directed towards the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible (W196 and W249), ensure objectives are developed necessary to meet the client's needs (W227), ensure data relative to the accomplishment of the criteria specified in client individual program plan	W 195			

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W 195	Continued From page 4 objectives are documented in measurable terms (W252), ensure the client's individual program plan is reviewed and revised annually (W260), ensure that client's individual program plan with restrictions is reviewed, approved and monitored by the Human Rights Committee (W262), and ensure that client's individual program plans are conducted with written informed consent (W263). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to the clients.	W 195			
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the team failed to assure that a continuous aggressive active treatment program was implemented for 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6) which provided consistent implementation of the individual program plan (IPP) and interventions in the facility, which promoted client function with as much	W 196			

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W 196	Continued From page 5 independence as possible and prevented regression of acquired skills. The findings are: A. Cross reference W227. The facility failed to ensure the IPP included guidelines to address identified needs relative to behavior management for 1 of 6 audit clients (#2). B. Cross reference W249. The facility failed to ensure 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the IPP. C. Cross reference W252. The facility failed to ensure data relative to the accomplishment of objective criteria was documented in measurable terms. This affected 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). D. Cross reference W260. The facility failed to update the current IPP for 5 of 6 audit clients (#1, #3, #4, #5 and #6). E. Cross reference W262. The facility failed to ensure the restrictive behavior techniques which included the use of psychotropic medication for 3 of 6 audit clients (#1, #2 and #6) was reviewed and monitored by the human rights committee (HRC). F. Cross reference W263. The facility failed to ensure written informed consent was obtained for clients restrictive Behavior Intervention Plans (BIP). This affected 3 of 6 audit clients (#1, #2 and #6).	W 196			
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)	W 227			

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W 227	<p>Continued From page 6</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure the individual program plan (IPP) included training to address identified needs relative to behavior management for 1 of 6 audit clients (#2). The finding is:</p> <p>During observations in the home on 1/11/21, client #2 was observed to walk out of the activity room, through the living room and into the dining room. Client #2's genitals were hanging out of the top of his pants. Additional observations in the home on 1/11/21 at 4:52pm revealed client #1, client #2 and client #3 in the activity room. Client #1 and client #3 were sitting in chairs, while client #2 was laying on the couch watching an iPad. Client #2 had his genitals out of his pants and was stimulating himself.</p> <p>Review on 1/12/21 of client #2's individual program plan (IPP) dated 4/5/20 did not reveal an identified need to address the behavior of self stimulation or pulling his genitals out in public areas. Additional review of client #2's record revealed a Behavior Intervention Plan (BIP) dated 3/29/20. The BIP identified target behaviors in the area of aggression, self-injurious behavior and property destruction. The BIP did not identify self-stimulation or pulling his genitals out in a public area as a need.</p>	W 227			

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W 227	Continued From page 7 Interview on 1/12/21 with Staff E revealed that when she sees client #2 exhibiting this behavior in a public area of the home, she will redirect him to stop or redirect him to his bedroom. Interview on 1/12/21 with the Home Manager (HM) revealed that he had not seen this behavior before, and that no training had been implemented to address this behavior. The HM stated if client #2 were to exhibit this behavior, he should be redirected to his bedroom to ensure his privacy.	W 227			
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plans (IPP's). The	W 249			

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W 249	<p>Continued From page 8 findings are:</p> <p>Throughout the survey on 1/11/21 and 1/12/21, all clients in the home were observed to sit in the living room, sit in their bedrooms, and sit and/or lay on the couch in the activity room. During the observations, staff were observed to sit in the living room watching television or use their personal cell phones. No clients were prompted or encouraged to actively participate in any form of active treatment.</p> <p>Interview on 1/12/21 with the Home Manager (HM) revealed that he completes an activity schedule each month for the clients and staff. The HM stated that staff typically follow the activity but he had just returned from an extended time off work, and the activity schedule was not completed in his absence.</p> <p>A. Review on 1/12/21 of client #1's record revealed an IPP dated 8/13/19. Additional review of client #1's record revealed no updated IPP since 8/13/19. Further review of client #1's record revealed no data collection for formal training objectives and programs for the period of 12/1/20 through 1/10/21.</p> <p>B. Review on 1/12/21 of client #2's IPP dated 4/5/20 revealed a training objective and program to use a picture/activity schedule to communicate his wants and needs every day.</p> <p>During observations in the home on 1/11/21 through 1/12/21, the picture/activity schedule was observed to be hanging on client #2's bedroom door. At no time during the survey was the picture/activity schedule used with client #2.</p>	W 249			

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W 249	Continued From page 9 C. Review on 1/12/21 of client #3's record revealed an IPP dated 1/15/19. Additional review of client #3's record revealed no updated IPP since 1/15/19. Further review of client #3's record revealed no data collection for formal training objectives and programs for the period of 12/1/20 through 1/10/21. D. Review on 1/12/21 of client #4's record revealed an IPP dated 5/22/19. Additional review of client #4's record revealed no updated IPP since 5/22/19. Further review of client #4's record revealed no data collection for formal training objectives and programs for the period of 12/1/20 through 1/10/21. E. Review on 1/12/21 of client #5's record revealed an IPP dated 6/13/19. Additional review of client #5's record revealed no updated IPP since 6/13/19. Further review of client #5's record revealed no data collection for formal training objectives and programs for the period of 12/1/20 through 1/10/21. F. Review on 1/12/21 of client #6's record revealed an IPP dated 2/19/19. Additional review of client #6's record revealed no updated IPP since 2/19/19. Further review of client #6's record revealed no data collection for formal training objectives and programs for the period of 12/1/20 through 1/10/21. Interview on 1/12/21 with the Program Director confirmed that the client's should have been prompted and encouraged to participate in active treatment.	W 249			
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1)	W 252			

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W 252	<p>Continued From page 10</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure data relative to the accomplishment of objective criteria was documented in measurable terms. This affected 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). The findings are:</p> <p>A. Review on 1/12/21 of client #1's data collection on her formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review.</p> <p>B. Review on 1/12/21 of client #2's data collection on his formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review.</p> <p>C. Review on 1/12/21 of client #3's data collection on his formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review.</p> <p>D. Review on 1/12/21 of client #4's data collection on his formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review.</p> <p>E. Review on 1/12/21 of client #5's data collection on his formal programs for the period of 12/1/20 through 1/10/21 revealed no data was</p>	W 252			

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W 252	Continued From page 11 available for review. F. Review on 1/12/21 of client #6's data collection on his formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review. Interview on 1/12/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she is sure staff are documenting data on training objectives and programs, and there must be a glitch in the system as to why no data is available. The QIDP confirmed that if no data is documented, it was not done.	W 252			
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to update the current annual individual program plans (IPP's) for 5 of 6 audit clients (#1, #3, #4, #5 and #6). The findings are: A. Review on 1/12/21 of client #1's record revealed an IPP dated 8/13/19. Additional review of client #1's record revealed no updated IPP since 8/13/19. B. Review on 1/12/21 of client #3's record revealed an IPP dated 1/15/19. Additional review of client #3's record revealed no updated IPP since 1/15/19.	W 260			

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W 260	Continued From page 12 C. Review on 1/12/21 of client #4's record revealed an IPP dated 5/22/19. Additional review of client #4's record revealed no updated IPP since 5/22/19. D. Review on 1/12/21 of client #5's record revealed an IPP dated 6/13/19. Additional review of client #5's record revealed no updated IPP since 6/13/19. E. Review on 1/12/21 of client #6's record revealed an IPP dated 2/19/19. Additional review of client #6's record revealed no updated IPP since 2/19/19. Interview on 1/11/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she had current IPP's on a thumb drive that was located at her office and she would bring the updated IPP to the facility on 1/12/21. Additional interview on 1/12/21 with the QIDP revealed no updated IPP was available.	W 260			
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior techniques which included the use of psychotropic medication for 3 of 6 audit clients (#1, #2 and #6) was reviewed and monitored by	W 262			

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W 262	<p>Continued From page 13</p> <p>the human rights committee (HRC). The findings are:</p> <p>A. Review on 1/11/21 of client #1's record revealed she is supported by a Behavior Intervention Plan (BIP) dated 11/30/18 to include the use of Invega, Cymbalta and Klonopin to address her behavioral needs.</p> <p>Review on 1/12/21 revealed no review or consent by the HRC for these behavior management medications.</p> <p>Interview on 1/12/21 with the Program Director revealed if no written review or consent by the HRC was available for review in client #1's record, it was not obtained.</p> <p>B. Review on 1/12/21 of client #2's record revealed he is supported by a BIP dated 3/29/20 to include the use of Clonazepam and Trazadone to address his behavioral needs.</p> <p>Review on 1/12/21 revealed no review or consent by the HRC for these behavior management medications.</p> <p>Interview on 1/12/21 with the Program Director revealed if no written review or consent by the HRC was available for review in client #2's record, it was not obtained.</p> <p>C. Review on 1/12/21 of client #6's record revealed he is supported by a BIP dated 4/1/19 to include the use of Risperdal and Ativan to address his behavioral needs.</p> <p>Review on 1/12/21 revealed no review or consent by the HRC for these behavior management</p>	W 262			

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W 262	Continued From page 14 medications.	W 262			
W 263	<p>Interview on 1/12/21 with the Program Director revealed if no written review or consent by the HRC was available for review in client #6's record, it was not obtained.</p> <p>PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure written informed consent was obtained for clients restrictive Behavior Intervention Plans (BIP). This affected 3 of 6 audit client's (#1, #2 and #6). The findings are:</p> <p>A. Review on 1/11/21 of client #1's individual program plan (IPP) dated 8/13/19 revealed client #1 is supported with a BIP. Review of client #1's record revealed a BIP dated 11/30/18 to address identified target behaviors consisting of property destruction, self-injurious behavior and hiding/stashing items. Additional review of the BIP dated 11/30/18 revealed client #1 is taking behavior management medications that includes Invega, Cymbalta and Klonopin. Further review of client #1's record revealed the last written consent signed by the guardian was obtained on 8/15/19.</p> <p>Interview on 1/12/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that</p>	W 263			

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W 263	<p>Continued From page 15</p> <p>written consent for client #1 has not been obtained since the last signed consent on 8/15/19.</p> <p>B. Review on 1/11/21 of client #2's IPP dated 4/5/20 revealed client #2 has an objective to "display 30 or fewer target behaviors as defined in his BIP for 4 out of 12 months." Additional review of client #2's record revealed a BIP dated 3/29/20 to address identified target behaviors consisting of aggression, self-injurious behavior and property destruction and is taking medication for behavior management that includes Clonazepam and Trazadone. Further review on 1/12/21 of client #2's record revealed no written informed consent signed by the guardian.</p> <p>Interview on 1/12/21 with the QIDP revealed that written informed consents for client #2's BIP and behavior management medications have been sent to the guardian but have not been received by the facility. The QIDP confirmed that client #2 has been receiving behavior management medications and has been supported by a BIP since 3/29/20 without having the guardian provide written informed consent.</p> <p>C. Review on 1/12/21 of client #6's IPP dated 5/22/19 revealed that client #6 is supported by a BIP. Review on 1/12/21 of client #6's record revealed a BIP dated 4/1/19 to address identified target behaviors and behavior management medications that includes Risperdal and Ativan. Further review of client #6's record revealed the last written consent signed by the guardian was obtained on 5/2/19.</p> <p>Interview on 1/12/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that</p>	W 263			

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W 263 W 331	<p>Continued From page 16 written consent for client #6 has not been obtained since the last signed consent on 5/2/19.</p> <p>NURSING SERVICES CFR(s): 483.460(c)</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, nursing failed to provide 2 of 6 audit clients (#1 and #5) with required services to meet the client needs. The findings are:</p> <p>A. During observations in the home on 1/11/21 at 5:30 pm, client #1 was given assistance by staff B to pour an unmeasured amount of water into a large glass with no marks for ounces and an unmeasured amount of milk into a small glass. Client #1 drank all of the fluids after eating her meal. An additional observation on 1/12/21 at 7:00 am, client #1 had a small glass of orange juice and a large glass of water. Neither glasses had information about the capacity for fluid ounces. Client #1 drank all of the fluids after eating her meal.</p> <p>Review on 1/11/21 of client #1's physician's orders, signed on 7/22/20, it stated that she was on an 80 ounce fluids restriction due to stage III chronic kidney disease.</p> <p>An additional review on 1/12/21 of client #1's daily fluid log, indicated that staff were not always recording her fluids during the day and/or did not always calculated her daily total. There was missing data during the months: January,</p>	W 263 W 331			

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W 331	<p>Continued From page 17</p> <p>February, July, November 2020 and January 2021. There were no instructions on how to record the fluids or instructions for the restrictions at meals and medication administration.</p> <p>During an interview on 1/12/21 with Staff E, she indicated that she already knew how many fluids each type of glass held, so could pour without measuring first. When asked how many fluids each glass held, staff E held each cup and stated 4 ounces for the small glass and 8 ounces for the large glass. Staff E was asked to demonstrate how much each glass held by using measured fluids to fill them. It was later determined that the small glass held 12 ounces and the large glass held 20 ounces.</p> <p>During an interview with the home manager (HM) on 1/11/21, he revealed that the facility had purchased a very large measuring cup, which was located in the kitchen's cabinet, for staff to use to measure client #1's drinks. The HM indicated that staff could not assume they were pouring the correct amount of fluids and that it had to be measured. He acknowledged that unmeasured fluid amounts might not reflect accuracy on the fluids log.</p> <p>An interview with the nurse on 1/12/21 regarding client #1's fluid restriction revealed she was supposed to monitor the fluids log but had not looked at it in awhile. The nurse indicated that the fluid log was supposed to contain a spreadsheet on how to measure the fluids. The nurse stated that client #1 was at risk of developing kidney failure if she had too many fluids and the staff needed to be retrained.</p> <p>B. Review of client #1's physician orders on</p>	W 331			

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W 331	<p>Continued From page 18</p> <p>7/22/20 required monitor of laboratory results of the comprehensive metabolic panel (CMP) every 3 months and the basic metabolic panel (BMP) and lipid test every 6 months. Review of the current laboratory tests were last completed in January 2020.</p> <p>An interview with the nurse on 1/12/21 revealed that she was responsible for monitoring that lab work was completed, per physician's orders. The nurse reviewed her records and indicated that the last laboratory test that she had on file for client #1 was in January 2020.</p> <p>C. Review on 1/12/21 of client #5's pharmacy review, dated 10/5/20 it called for clarifying if client #5 should remain on Amlodipine 10 mg daily due to an allergy to calcium channel blockers. The pharmacist requested, "Please clarify this allergy and provide documentation if [client #5] can take this medication with no adverse effects." There was no response from the physician to the pharmacist.</p> <p>A review on 1/12/21 of client #1's medication administration records (MAR) since October 2020, indicated that he has continued to receive a daily dose of Amlodipine 10 mg.</p> <p>An interview on 1/12/21 with the nurse, revealed she visited the home monthly and was responsible for reviewing the quarterly pharmacy reviews and following up with the physician if necessary. The nurse acknowledged that she did not recall the pharmacist's request and must have overlooked her comments.</p>	W 331			
W 340	<p>NURSING SERVICES CFR(s): 483.460(c)(5)(i)</p>	W 340			

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W 340	<p>Continued From page 19</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>This STANDARD is not met as evidenced by: Based on observations, policy review and staff interviews, the facility failed to ensure staff were sufficiently trained in adhering to their COVID-19 policy; and ensure that staff report new health conditions to the nurse.</p> <p>A. During observations in the home on 1/11/21 at 12:30 pm, the qualified intellectual disabilities professional (QIDP) entered the home, wearing a loose fitting surgical mask, that sometimes exposed her nostrils. The QIDP was not observed taking her body temperature or recording answers on the facility's COVID-19 screening form. The questions on the form contained the following:</p> <ol style="list-style-type: none"> 1. Have you or anyone in your home been out of the country in the past 21 days? 2. Is anyone in your home currently showing symptoms of fever of 100 degrees or higher, cough, runny nose, sneezing, diarrhea, vomiting, nausea, and /or respiratory issues? 3. Have you been in contact with anyone in the last 21 days who has been diagnosed with the coronavirus or shown symptoms of the flu? 4. Will you be attending any large venue events that will bring you and/or your loved one in contact with a group of people consisting or 25 or more? 	W 340			

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W 340	<p>Continued From page 20</p> <p>In addition, the QIDP was observed having random coughs as well as complaining about being hot, until the end of the observation at 6:00 pm.</p> <p>The following day, 1/12/21, the QIDP arrived at the home at 9:30 am and was wearing a face mask. The QIDP was observed to not take her temperature or answer any of the screening questions. She was observed coughing, sweating and told a surveyor that she had to see a doctor today because she felt "like a truck hit her." The QIDP left the facility at 9:55 am.</p> <p>Review on 1/11/21 of the facility's COVID-19 Emergency Preparedness Plan, dated 2/1/20 revealed that staff must take their temperature and if over 100.0 degrees must immediately leave premises and cannot work without clearance from a medical doctor and a negative COVID-19 test.</p> <p>Review on 1/12/21 of the facility's temperature log binder required that "All Kenwood Staff Must Take Their Temperature Before Starting Their Shift." There were no screening forms for the QIDP on 1/11/21 and 1/12/21, however the other staff on duty, had completed forms.</p> <p>Interview on 1/12/21 with the QIDP regarding the employee COVID-19 screening process, she insisted that she had completed the forms but did not produce copies.</p> <p>B. On 1/12/21, the survey team entered the home between the hours of 6:00-7:00 am. Two staff were on third shift duty, staff D and staff E. Neither staff recorded body temperature of the two surveyors and or requested that COVID-19</p>	W 340			

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W 340	<p>Continued From page 21 screening forms being completed upon entering the home.</p> <p>Interview on 1/12/21 with staff E revealed that she had not dealt with any visitors on her shift since the pandemic, so it did not occur to her to request health screening.</p> <p>Interview on 1/12/21 with staff D revealed that he did not ask the survey team to be screened because he made the assumption that we were COVID-19 free since we were conducting surveys.</p> <p>Interview on 1/12/21 with the house manager (HM) revealed that it was the facility's policy, which was posted throughout the house, that every employee and every visitor must be screened. The HM explained that he conducted staff meetings twice a month and had repeatedly covered his expectations.</p> <p>Interview on 1/12/21 with the nurse revealed training on COVID-19 was offered to staff on 12/15/20. The nurse stated that everyone, including the QIDP should be screened when entering the home. The nurse explained if the screening was bypassed, it could potentially infect consumers and staff since COVID-19 was highly contagious.</p> <p>C. During observations in the home, over 1/11/21 and 1/12/21, client #5 was observed coughing on occasion; client #1 and #6 were observed sneezing and client #2 and #3 were observed wiping nasal drainage across the back of their hands.</p> <p>Review of the client #1, #2, #3, #5 and #6's</p>	W 340			

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W 340	Continued From page 22 medical record had no documentation of any new health condition that related to sneezing, coughing and runny nose. Interview on 1/12/21 with staff E regarding client #5 coughing over the last two days revealed that she had not noticed any coughing. She stated that if she was aware that he was coughing, she would immediately contact the nurse. Interview on 1/12/21 with the nurse revealed that her expectation was for staff to relay any new symptom to her immediately. She further stated that staff were present at an in-service last month that discussed COVID-19 and any potential symptoms. The nurse stated that had she known that some of the clients and staff had potential COVID-19 symptoms, she would immediately put all clients on quarantine, requiring them to stay inside of their rooms. All clients and staff would have to be tested and staff wear full personal protective equipment (gowns, gloves, face masks and face shields). Interview on 1/12/21 with the program director revealed that since the pandemic, that if any client developed a cough, sneezing or runny nose, the nurse would issue a quarantine for the home.	W 340			
W 374	DRUG ADMINISTRATION CFR(s): 483.460(k)(7) The system for drug administration must assure that drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law.	W 374			

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W 374	Continued From page 23 This STANDARD is not met as evidenced by: Based on observation, interviews and document review, the facility failed to ensure all drugs were packaged and labeled in accordance with State law. This affected 1 of 6 audit clients (#1). The finding is: During observations on 1/12/21 during medication administration, Staff D was observed to administer Artificial Tears, one drop in each eye, to client #1. The bottle of Artificial Tears was not labeled. Interview on 1/12/21 with Staff D confirmed that the bottle of Artificial Tears was not labeled with a pharmacy label to identify the client, the person prescribing the medication, and dosage information. Staff D reported that the bottle of Artificial Tears did not require a label because the bottle had manufacturer dosing instructions on the side of the bottle. Interview on 1/12/21 with the facility nurse confirmed that the bottle of Artificial Tears should have been labeled with a pharmacy label.	W 374			
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:	W 436			

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W 436	<p>Continued From page 24</p> <p>Based on observations, record review and staff interviews, the facility failed to furnish eye glasses for 1 of 6 audit clients (#1) with visual impairment. The finding is:</p> <p>During observations in the home on 1/11/21-1/12/21, client #1 did not wear any eye glasses. An additional observation on 1/11/21 of client #1 placing cartons of yogurt next to each client's place setting, revealed that client #1 had trouble with her vision and staff C had to guide her hand to the correct location.</p> <p>Review on 1/11/21, an undated photograph of client #1 in her medical chart, displayed her wearing eye glasses. An additional review of client #1's individual program plan, dated 8/13/19 revealed that she had severe myopia with astigmatisms and bilateral cataracts.</p> <p>Interview on 1/12/21 with the home manager revealed that he had worked in the home for three years and never knew that client #1 wore glasses. He did not know the status of her prescription.</p> <p>Interview on 1/12/21 with the nurse revealed that she had worked at the home for three years and made monthly visits. The nurse stated that she was unaware that client #1 needed eye glasses and would need to follow up.</p>	W 436			