PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		С
		34G143	8. WING		09/22/2020
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	1	TREET ADDRESS, CITY, STATE, ZIP CODE	1
KEYWEST	r CENTED		1	722 ATHENS AVENUE	
VE I AAE S I	VENILA		1 0	URHAM, NC 27707	
(X4) ID PREFIX TAG	ÆACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAĞ	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY).	SHOULD BE COMPLETION
E 006	CFR(s): 483.475(a)(1 [(a) Emergency Plan and maintain an eme	. The (facility) must develop ergency preparedness plan	€ 006	The Keywest	management updated
	2 years. The plan m (1) Be based on and facility-based and co	include a documented,		its Hazard Vuli Analysis (Haz Assessment)	ards Risk
	*[For LTC facilities at Plan. The LTC facility an emergency prepa reviewed, and updat must do the following (1) Be based on and	s §483.73(a)(1):] Emergency y must develop and maintain aredness plan that must be ed at least annually. The plan g: include a documented,		disasters in the Central Region recent natura	u disasters
	including missing res (2) Include strategies events identified by the *[For ICF/IIDs at §48]	g an all-hazards approach, sidents. s for addressing emergency		Procedure and Of Keywest	Practices Center
	emergency prepared reviewed, and updat plan must do the foll (1) Be based on and facility-based and co assessment, utilizing including missing cli (2) Include strategie	diness plan that must be ted at least every 2 years. The lowing: i include a documented, ommunity-based risk g an all-hazards approach,		The emerger Procedure and identifies de Safe areas	
ļ	* [For Hospices at §	418.113(a)(2):] Emergency		mail box at a	Ariveway_

Any deficiency statement ending with an adverse of 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

Event IO: 1XKK11

program participation.

Facility (D: 922086

if continuation sheet Page 1 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G143	B. WING	·	C 09/22/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/22/2020
KEYWEST	CENTER			1722 ATHENS AVENUE DURHAM, NC 27707	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÒ PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
	Plan. The Hospice must emergency prepared reviewed, and update plan must do the follor (1) Be based on and i facility-based and con assessment, utilizing (2) Include strategies events identified by the including the manager of power failures, nature emergencies that wou ability to provide care. This STANDARD is made and facility-based risk all-hazards approach, affect all clients, participandemic. The finding The facility did not have assessments.  Review on 9/21/20 of dated for 10/31/18, review on 9/21/20 of dated for 10/31/18, review on 9/21/20 will disabilities professions facility had not obtaine assessment.	ust develop and maintain an ness plan that must be d at least every 2 years. The wing: include a documented, inmunity-based risk an all-hazards approach, for addressing emergency le risk assessment, inment of the consequences ural disasters, and other all affect the hospice's lot met as evidenced by: we and interview, the facility mergency preparedness and based upon a community assessment utilizing an This had the potential to cularly during a Coronavirus is:  We an EP plan based on risk the facility's current EP plan wealed the plan did not leation in regards to a lessment utilizing an with the qualified intellectual all (QIDP), revealed that the did a facility-based risk	E 006	entrance; tornal center protected point of the fact window access, bathroom #2). It case of missing individuals, strowledge of residents where in the group how will allow them locate and move residents to the designated safe	dility d in aff's abouts me, to
	hurricanes did not effe				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 2 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G143	B. WING		C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1722 ATHENS AVENUE DURHAM, NC 27707	09/22/2020 DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ULI IDILIDAY)	N SHOULD BE COMPLÉTION
E 022	considered identifying train staff. Policies/Procedures if CFR(s): 483.475(b)(4  (b) Policies and procedure policies and procedure plan set forth in paragases sment at paragand the communication this section. The policies reviewed and upda (annually for LTC).] A and procedures must [(4) or (2),(3),(5),(6)] or patients, staff, and the [facility].  *[For Inpatient Hospic and procedures. (6) The following are a hospice-operated inpation policies and procedures. (7) A means to shelter hospice employees with STANDARD is no Based on record reviewed.	edures. The [facilities] must and emergency preparedness res, based on the emergency praph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least every 2 years to a minimum, the policies address the following:]  A means to shelter in place of volunteers who remain in the set §418.113(b):] Policies additional requirements for atient care facilities only, edures must address the	E 022	Keywest's man implemented a Dut a shelter Plan authoristhe State, Cand city gove ordiance but wasn't in planter in pl	zea by bunty comment titing. a020, agement uritten ice plan
	all clients residing in the facility's EP plan of	heir emergency an. This potentially affected he home. The finding is; did not address any plans to a pandemic response.		Pandemic a by stategove including loc city government	s sanction rnment qladzo al county-

FORM CMS-2587(02-99) Previous Versions Obsolete

Event IQ:1XKK11

Facility ID: 922085

if continuation sheet Page 3 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	СОМ	SURVEY PLETED
		34G143	B. WING			1	C /22/2020
NAME OF PI	ROVIDER OR SUPPLIER			1	STREET ADDRESS, GITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	8 <b>2</b>	(X5) COMPLETION DATE
E 0225	Review on 9/21/20 of developed on 10/31/1 for situations that word staff to shelter in place disabilities profession facility had not incorpose their EP plan.  Arrangement with Ott CFR(s): 483.475(b)(7)  [(b) Policies and procedure plan set forth in paragular set forth in pa	the facility's EP plan 8 did not include language ald call for the clients and e.  with the qualified intellectual al (QIDP), revealed that the orated a pandemic policy in  her Facilities  adures. The [facilities] must nt emergency preparedness es, based on the emergency graph (a) of this section, risk taph (a)(1) of this section, on plan at paragraph (c) of clies and procedures must ated at least every 2 years t a minimum, the policies address the following:]  8.113(b), PRFTs at s at §482.15(b), and LTC b):] Policies and procedures, pment of arrangements with other providers to receive of limitations or cessation of the continuity of services	E	022	DEFICIENCY	ment rry Hom ment ntract ement roup 19 newa	e.
	development of arrang	gements with other	**************************************			•	

FORM CMS-2567(82-99) Previous Versions Obsolete

Event ID; 1XKK11

Facility ID: 922086

If continuation sheet Page 4 of 37

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			RUCTION							SURVEY PLETED
	•	34G143	B. WING _				-	_					C 122/2020
NAME OF PI	ROMDER OR SUPPLIER	Margar France	]		TREET/	ADDRESS,	CITY,	STATE,	ZIP C	ODE	i	, A2	/22/2020
						IENS AVE		•		•••			,
KEYWEST	CENTER			D	URHAI	M, NC 27	7707						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG				CORR	RECTIVI	EACT	HE APP	OULD BE		(X5) COMPLETION DATE
E 025	Continued From page	s 4	E(	025				,		. ' .			 
		roviders to receive patients							•	>		•	:
	in the event of limitation	ions or cessation of									,		ļ · ·
	operations to maintain to facility patients.	n the continuity of services				,	^						,
					'	, ;				• ,			
	*[For RNHCIs at §403 procedures. (7) The d	3.748(b):] Policies and										,	i 
		her RNHCIs and other				٠,	•					•	
		patients in the event of		ì	ì								
	limitations or cessation	on of operations to maintain				'	*						
	the continuity of non-nipatients.	medical services to RNHCI										,	ļ ,
	This STANDARD is n	not met as evidenced by:	Ì			,							: I
		and review of the facility's	Ī										
		ness (EP) plan, the facility			٨								į
	failed to document pre	e-arranged clients in the event services			ļ	•	,	* .	٠				
	could not be delivered			!	!							٠,	<u> </u>
		I clients in the home. The											i i
	finding is:			1	1.	8 4				١	. :	(X.5),	· 
	The facility failed to lis accommodations in th				} }		. ,			*	i.		, ,   
	moonimity ()	ion in plan.		ļ	ļ								i I
	no listing of accommo	8 revealed that there was produced for arrangements for		ļ									
	emergency purposes.				ļ	V 1		,					; i
	Interview on 9/22/20 v	with staff B, revealed that		į	[							·	
	when hired four month	hs ago, he received training of know where to take clients					۲		•	Ŧ		•	
15	disabilities professiona	with the qualified intellectual al, revealed that the facility EP plan to inform staff for emergency			٧.	**			•				· ,

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922085

If continuation sheet Page 5 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED .	
فيبند	<b>.</b>	34G143	B. WING		C 09/22/2020	
•	ROVIDER OR SUPPLIER I CENTÉR			STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707		·
(X4) ID AREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE	
€ 037	CFR(s): 483.475(d)(1)  "[For RNCHIs at §40: Hospitals at §482.15, at §484.102, "Organiz OPOs at §486.360, For Training program. The following:  (i) Initial training policies and procedures affi, individuals provarrangement, and vo expected roles.  (ii) Provide emer at least every 2 years (iii) Maintain door preparedness training (iv) Demonstrate emergency procedure (v) If the emerge and procedures are selfacility] must conduct policies and procedures are selfacility] must conduct policies and procedures are selfacility] must do all conduction of the policies and procedures are selfacility of the emergency employees, services under arrane expected roles.  (ii) Demonstrate emergency procedur (iii) Provide eme at least every 2 years (iv) Periodically in the selface of the policies and procedures are selfaced roles.	3.748, ASCs at §416.54, ICF/IDs at §483.475, HHAs zations" under §485.727, IHC/FQHCs at §491.12:] (1) In effacility] must do all of the sin emergency preparedness res to all new and existing iding services under funteers, consistent with their gency preparedness training is umentation of all emergency grant staff knowledge of es. Incomparedness policies significantly updated, the attraining on the updated res. Its.113(d):] (1) Training. The fifthe following: In emergency preparedness res to all new and existing and individuals providing gement, consistent with their staff knowledge of es. Ingency preparedness training in gency preparedness training individuals providing gement, consistent with their staff knowledge of es. Ingency preparedness training in emergency preparedness training in the provider in gency preparedness training in the provider in	E 03	Keywest manage will continue to implement an information en the attention staff.  Update training son 10/10/2020.  emergency preparation were reversed with a plans were reversed with a presented with disaster scenary which require to excute and exercise and exercis	gaging of was rows lewed, ency were various rios at them	20

EVOIR BUT DATABASE

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
		34G143	B. WNG_		09	C /22/2020	
NAME OF P	ROMDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP GODE 1722 ATHENS AVENUE DURHAM, NC 27707		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
E`037	procedures necessar others.  (v) Maintain docupreparedness training (vi) If the emerge and procedures are shospice must conduct policies and procedure for PRTFs at §441. program. The PRTF (i) Initial training policies and procedure staff, individuals proviating policies and procedure staff, individuals proviating policies and procedure (ii) After initial training (iii) Demonstrate emergency procedure (iv) Maintain docupreparedness training (v) If the emergency	y to protect patients and  umentation of all emergency incy preparedness policies ignificantly updated, the training on the updated es.  184(d):] (1) Training must do all of the following: in emergency preparedness es to all new and existing ding services under unteers, consistent with their ining, provide emergency pevery 2 years, staff knowledge of es. umentation of all emergency incy preparedness policies ignificantly updated, the raining on the updated	E 03	Provided staff opportunity to address their techniques a consequences unsatisfactor performance fire, tornado, pandemic, ice storm, severe thunderstorm and earthqua	nd for "i.e.	X0/202	
,	*[For LTC Facilities at Program. The LTC fac following: (i) Initial training i policies and procedur staff, individuals provi arrangement, and vol- expected role. (il) Provide emergat least annually.	§483.73(d):] (1) Training cility must do all of the n emergency preparedness es to all new and existing					
	Annah samman	· · · · · · · · · · · · · · · · · · ·		3			

FÖRM, CM5-2567(92-99) Previous Versions Obsolete

Evant ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 7 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		LE CONSTRUCTION		DATE S	SURVEY ETED
		34G143	B. WING _	-			O 09/2	2/2020
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE		0012	AC A GALC
VEIMED	CENTER		ŀ	ı	DURHAM, NC 27707			
(X4) ID PREFIX TAG	(ÉACH DEFICIÉNC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÓ PREFII TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE		(X5) COMPLETION DATE
E 037	Continued From page	• 7	E	337	7			
	preparedness training	1.			·		-	
		staff knowledge of			,	* ··		
	emergency procedure	•			,			
	_ ·				,			
	*[For CORFs at §485]	.68(d):](1) Training. The					}	
	CORF must do all of t	the following:					ĺ	
		training in emergency			,			
		s and procedures to all new	1		,			
	and existing staff, ind		ļ		V - 1 - 3			
	_	rement, and volunteers,				•		
	consistent with their e							
		gency preparedness training			•			
	at least every 2 years				,	. , •		
		umentation of the training,			2			,
		staff knowledge of					ļ	
		es. All new personnel must			*			
	be oriented and assig				•			
	reenensibilities re	regarding the CORF's	!					
i		program most include	i		<del>-</del> :		i	i
	workday. The training instruction in the local	, •						
		and firefighting equipment.					,	
		and menghing equipment. ancy preparedness policies			· ·		I	
		ignificantly updated, the				- 1	:	
	CORF must conduct t					*		
	policies and procedure	· · · · · · · · · · · · · · · · · · ·						
	boundarie in the contraction	,						
	*IFor CAHs at \$485.6	25(d):] (1) Training program.						
	The CAH must do all	of the following:						1
		n emergency preparedness	ļ					
	policies and procedure		•				ĺ	
	reporting and extingui					•		ł
		evacuation of patients,						Ì
	personnel, and guests		- Landard - Land					
	cooperation with	firefighting and disaster	and on the second					
	authorities, to all new		out					ļ
		ervices under arrangement,	out out of the control of the contro					
		onsistent with their expected	-					
		The second secon						ļ
	· · · · · · · · · · · · · · · · · · ·						I	

FORM GMS-2587(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 8 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		34G143	B. WING		C 09/22/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707		
(X4) IĎ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION	
E 037	roles.  (ii) Provide emer at least every 2 years (iii) Maintain doc (iv) Demonstrate emergency procedures (v) If the emerg and procedures are s CAH must conduct to policies and procedures and procedures and procedures preparedness policies and existing staff, ind under arrangement, a with their expected rodocumentation of the demonstrate staff knot procedures. Thereaft emergency prepared years.  This STANDARD is r Based on record revifacility failed to conduct (EP) plan training for hires. This potentially finding is:  Staff did not receive E Review on 9/21/20 of revealed that there we EP training for all staf contained training she Furthermore, the name	gency preparedness training in umentation of the training. It is staff knowledge of eas. It is ency preparedness policies alignificantly updated, the aining on the updated res.  5.920(d):] (1) Training. The initial training in emergency is and procedures to all new initial training in emergency is and procedures to all new initial training. The CMHC must by less, and maintain training. The CMHC must by less training at least every 2 mot met as evidenced by: lew and interviews, the lot emergency preparedness staff annually and for new affected all clients. The	E	037		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility (D: 922085

If continuation sheet Page 9 of 37

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, -		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		34G143	B. WING			ł	C
NAME OF P	ROVIDER OR SUPPLIER	320143	p. ma.	8	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	22/2020
					722 ATHENS AVENUE		
KEYWEST	CENTER			Đ	DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
É 037	Interview on 9/22/20 had not received trair since his hire four mount interview on 9/22/20 hintellectual disabilities revealed that she countraining for the EP plan linterview on 9/22/20 she did not conduct a EP plan due to the Content in the EP Testing Requirement.	with staff B, revealed that he ning on the EP plan policy on the assistant qualified a professional (QIDP), and not produce any current an policy.  with the QIDP, revealed that any training this year on the pronavirus pandemic.		037	The Keywest manage Conducted exercise	men	
	HHAs at §484.102, C "Organizations" unde §485.920, RHC/FQHo Facilities at §494.62]:  (2) Testing. The [facilities at §494.62]:  (2) Testing. The [facilities at §494.62]:  (3) Testing. The [facilities at §494.62]:  (i) Participate in a community-based every 2  (B) If the [facilities at §494.62]:  (E) Participate in a facilities at §494.62]:  (E) Participate in a facilities at §494.62]:  (E) Testing. The [facilities at §494.62]:  (E) Participate in a facilities at §494.62]:  (E) Testing. The [facilities at §494.62]:  (E) Participate in a facilities at §494.62]:  (E) Testing. The [facilities at §494.62]:  (E) Testin	ity] must conduct exercises y plan annually. The [facility] owing: a full-scale exercise that is ery 2 years; or community-based exercise is uct a facility-based functional years; or cility] experiences an actual emergency that requires			conducted exercises test the identified hazards for the No Central Region und the direction of the direction	risk with Her Hhe S redok	<b>35</b>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922088

If continuation sheet Page 10 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE : COMPL	
		34G143	B. WING		09/2	22/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1722 ATHENS AVENUE DURHAM, NC 27707 PROVIDER'S PLAN OF C	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTIV	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
. € 039	functional exercise to this section is conduct not limited to the foll (A) A second community-based or functional exercise; (B) A mock (C) A tablet is led by a facilitator discussion using a not clinically-relevant set of problem states prepared questions emergency plan.  (iii) Analyze maintain documentate exercises, and emergency plan.  (iii) Analyze maintain documentate exercises, and emergency plan.  (iii) Testing for hospical patient's home. The exercises to test the annually. The hospical community based error (A) When a community based functional exercises to test the annual exercises to test the annually. The hospical functional exercises to test the annually. The hospical functional exercises to test the annually based functional exercises to test the annual emergency plexempt from engagiscale community-based the onset of the emergency plane (ii) Conduct and (iii) Conduct and (iiii) Conduct and (iiiii) Conduct and (iiiiiii) Conduct and (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	inder paragraph (d)(2)(i) of cted, that may include, but is owing: Individual, facility-based or disaster drill; or op exercise or workshop that and includes a group arrated, interregency scenario, and a ments, directed messages, or designed to challenge an ethe [facility's] response to and ation of all drills, tabletop gency events, and emergency plan, as needed.  18.113(d):] ices that provide care in the hospice must conduct emergency plan at least ice must do the following: In a full-scale exercise that is very 2 years; or a community based exercise is duct an individual facility ercise experiences a natural gency that requires activation and, the hospital is ng in its next required full ised exercise or individual functional exercise following	E	change and a specific and specific and conducted as exercise the facility base included a light base included	best esidents center acilitator full-scale at was d which mock ill and ussion elevant	79010

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922088

If continuation sheet Page 11 of 37

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	PLE CONSTRUCTION 3		ATE SURVEY OMPLETED	
		34G143	B. WING	·	1	C /22/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 039	functional exercise un this section is conduct not limited to the followard (A). A second community-based or exercise; or (B). A mock (C). A tablete is led by a facilitator addiscussion using a nate clinically-relevant set of problem statem prepared questions emergency plan.  (3) Testing for hospical care directly. The hospical care directly bear of the emergency plane exempt from engaging full-scale community bear of the emergency ever (ii) Conduct an atthat may include, but if following:  (A) A second community-based or a exercise; or	der paragraph (d) (2)(i) of ted, that may include, but is wing: d full-scale exercise that is a facility based functional disaster drill; or op exercise or workshop that and includes a group rrated, emergency scenario, and a tents, directed messages, or designed to challenge an est that provide inpatient spice must conduct emergency plan twice per ust do the following: an annual full-scale exercise sed; or community-based exercise is ct an annual individual al exercise; or spice experiences a natural ancy that requires activation in, the hospice is g in its next required exercise following the onset int. dditional annual exercise	EOS		ê.		
	(b) Millocki	715457B1 (1188, ÚI	AAAAAA				

	OF DEFICIENCIES FORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		E SURVEY PLETED
			7. 25.00	11443			c
		34G143	B. WING			Į.	/22/2020
NAME OF P	RÖVIDER ÖR SUPPLIER	<u></u>		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
KEYWEST	CENTED				1722 ATHENS AVENUE		
1 (2m 1 (4 m/m)	Cmi41mi7	12.44			DURHAM, NC 27707		
(X4) ID		ATEMENT OF DEFICIENCIES	(D		PROVIDER'S PLAN OF CORRECTION	-	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					DEFICIENCY)		
E 039	Continued From page		E	039	9		
		op exercise or workshop led					
	*	cludes a group discussion	}				
	using a narrated,	clinically-relevant					
<b>1</b>	emergency scenario,	and a set of problem messages, or prepared					
		signed to challenge an					
,	emergency plan.	ignor is similarity and					
		hospice's response to and					
		on of all drills, tabletop					
	exercises, and emergency events and revise the hospice's emergency plan, as needed.						
	*For PRFTs at §441.	194/d) Manajenia at					
	§482.15(d), CAHs at §				·		
		F, Hospital, CAH) must					
		est the emergency plan	•				
		PRTF, Hospital, CAH] must					
	do the following:	- · · · · ·					
, , [ ]	participal and a second of the second		i l		1		
					r. camera		į į
		community-based exercise is ct an annual individual,			ne de la companya de		l i
	facility-based function		***				
		TF, Hospital, CAH]	***************************************				<b>[</b>
	experiences an actual						
	emergency that requir	es activation of the					
	- "	facility] is exempt from	R.				ļ
		quired full-scale community					
	based or	individual, facility-based	***************************************				
	emergency event.	lowing the onset of the					
		dditional] annual exercise or					
	and that may include	but is not limited to the	***************************************				
	following:						<b> </b>
1	•••	full-scale exercise that is	******				
		ndividual, a facility-based	***************************************		The state of the s		
	functional exercise; or	-	***************************************		Venezuoissa		
	(B) A mock d	isaster drill; or				ľ	
			***************************************				

FORM CMS-2567(02-88) Previous Versions Obsolete

Event ID; 1XKK11

Facility ID: 922088

If continuation sheet Page 13 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION			SURVEY PLETED
		34G143	B. WING				I	C (22/2020
NAME OF PI	ROVIDER OR SUPPLIER	V40140	1 0, 11,10	STREE	TADDRESS, CITY, STATE, ZIP CODE	<u></u>	09	/22/2020
.,				•	THENS AVENUE			
KEYWEST	CENTER			DURH	IAM, NC 27707			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	מו		PROVIDER'S PLAN OF COR	RECTION		(X(\$)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFII TAG	(	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)			COMPLETION DATE
E 039	Continued From page	⇒ 13	E	39				
	(C) A tableto	pp exercise or workshop that						
	is led by a facilitator a	and includes a group						
	discussion, using a na							
		t emergency scenario, and a						
	·	ents, directed messages, or						
	prepared questions	designed to challenge an						
	emergency plan.	facility of company to and						
		facility's] response to and ion of all drills, tabletop						
	exercises, and emerg							
	the [facility's] emerger	•						
	*[For LTC Facilities at	\$483.73(d):1						
	•	must conduct exercises to						
		lan at least twice per year,						
	including unannounce	ed staff drills using the						
	emergency procedure			\$				
	[CF/IID] must do the f	following:						
	* *	an annual full-scale exercise						
	that is community-bas	•						
		community-based exercise is						
		ict an annual individual,						
	facility-based function	ial exercise. 'C facility] facility experiences						i
		nan-made emergency that						
	requires activation of			-				
	•	mpt from engaging its next						
	required a full-scale c							
		-based functional exercise						1
	following the onset of	the emergency event.	}					
		dditional annual exercise						
	that may include, but i	is not limited to the						
	following:	166						
·		d full-scale exercise that is	Webcasa .					
		an individual, facility based						
	functional exercise; or		en e	1				
		disaster drill; or	on and an and an					ļ <b>l</b>
	(C) A (B)	op exercise or workshop that						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility (D: 922088

If continuation sheat Page 14 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. <u>0938-0391</u>

	O LOU MEDIAVICE OF	MEDICAID SERVICES				2214177 5 4 27	7. 0000-000
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
							0
		34G143	B. WING			09/	22/2020
NAME OF P	ROMDER OR SUPPLIER	*****		-	STREET ADDRESS, CITY, STATE, ZIP CODE		
				١.	1722 ATHENS AVENUE		
KEYWEST CENTER					DURHAM, NC 27707		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ΙĎ		PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	ŘEGULAIORT UR I	SCIDENTIFTING INFURIWALIUM)	IAĢ		הייסק-אפרפאכוטבט וט זחב איראטיראע DEFICIENCY)	HTE	2.772
E 039	set of problem statem prepared questions emergency plan. (iii) Analyze the I maintain documentati exercises, and emergethe ICF/IID's emerger "[For OPOs at §486.3 (d)(2) Testing. The OI	nents, directed messages, or designed to challenge an CF/IID's response to and ion of all drills, tabletop lency events, and revise ncy plan, as needed.	E.	039	3		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/30/2020 FORM APPROVED

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					OMB NO	). 0938-03 <u>91</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		e construction	•	(X3) DATE COMP	SURVEY PLETED
		34G143	B. WING			_	l	C /22/2020
NAME OF P	ROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
					1722 ATHENS AVENUE			
KEYWEST	CENTER				DURHAM, NC 27707			·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	using a narrated, emergency scenario, statements, directed requestions desembles desembles des emergency plan.  (iii) Analyze the directed response to and main drills, tabletop exercise events, and revise the emergency plan, as not expense to a servents and revise the emergency plan, as not locally and the local desembles desired and the local desembles desired and taccessible, conduct facility-based functions (B) If the ICF natural or man-made activation of the emergency events and functional of the emergency events discussion, based functional exercise; or (B) A mock of (C) A tableto is fed by a facilitator and discussion, using a narrated response to a functional exercise; or discussion, using a narrated response to a functional exercise; or discussion, using a narrated response to a functional exercise; or discussion, using a narrated response to a functional exercise; or discussion, using a narrated response to a functional exercise; or discussion, using a narrated response to a functional exercise; or discussion, using a narrated response to a functional exercise; or discussion, using a narrated response to a functional exercise; or discussion, using a narrated response to a functional exercise; or discussion, using a narrated response to a functional exercise; or discussion, using a narrated response to a functional exercise; or discussion, using a narrated response to a functional exercise.	clinically-relevant and a set of problem messages, or prepared igned to challenge an  [LTC facility] facility's tain documentation of all es, and emergency e [LTC facility] facility's eeded.  3.475(d)]:  [D must conduct exercises plan at least twice per year. the following; an annual full-scale exercise eed; or community-based exercise is ct an annual individual, al exercise; or.  [//IID experiences an actual emergency that requires gency plan, the ICF/IID ing in its next required based or individual, facility- exercise following the onset int. dictional annual exercise that it limited to the following: I full-scale exercise that is an individual, facility-based  lisaster drill; or p exercise or workshop that ind includes a group	E	039				

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility (0: 922086

If continuation sheet Page 15 of 37

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		346143	B. WING			l	C <b>22/2020</b>
NAME OF D	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 007	£212.42.0
MAINE OF FI	MONDEM ON GOFFEIGH				722 ATHENS AVENUE		
KEYWEST	CENTER		1	Đ	URHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
€ 039	after he was hired for participate in any EP Interview on 9/22/20 disabilities profession not conducted any full	the facility's EP plan  18, did not include a  or tabletop exercise.  with staff B, revealed that  ur months ago, he did not	E	039			
W 000	completed on Septem #NC00162457 and N complaints were subs	complaint survey was nber 22, 2020 for Intakes C00167330. Both stantiated. Deficiencies	W	000	:		
W 122	the recertification sur CLIENT PROTECTIO CFR(s): 483.420	ONS ure that specific client	w		Completed 9/22/2 Since the most recent Survey, Keywest manage and staff have not ence	m) for	ed
	The facility failed to: and procedures that in neglect and abuse of to thoroughly investig neglect and mistreatr	the client (W149) and failed attentions of abuse, nent to clients (W154).		•	any life endangered inc Management conducted in With its QP's and impro its guidelines for respo to life threatening situ as indicated:	n-Serv oved nding	ing

FORM CMS-2557(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 17 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	NG	(X3) DATE SURVEY COMPLETED
			7. 00.001		c
		34G143	B, WING		09/22/2020
	RÖVIDER OR SUPPLIER T CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION APPROPRIATE DATE
W 149	statutorily mandated to its clients. STAFF TREATMENT CFR(s): 483.420(d)(1) The facility must dever policies and procedur mistreatment, neglect that procedures and #4) after (DC #6) 7/4/20 and subseque Review on 9/21/20 of 7/4/2020 at 4:30 pm to DC #6 was sitting at the review indicates he was consuming to much folient twice, [DC #6] of staff prompt him to slichoking, staff member 11 was dispatched to continue CPR on client review on 9/2 revealed a second states.	of CLIENTS  clop and implement written res that prohibit to rabuse of the client.  not met as evidenced by: n, record review and staff failed to assure its policies prohibit neglect were ent neglect for 4 of 5 clients ( ne deceased client (DC #6) nis finding. The findings are: ent failed to retrain staff on diets for 2 of 5 clients (#1 choked during mealtime on ntly died. For example:  an incident report dated revealed at a facility cookout the table eating. Further		The designated on-commediately when immediately when the stroke, suicidal etc.).  The designated in Shall immediately an inquiry into the situation withall and residents the involved or encountry into the detailed document willing the mergency residents to assist in its report fill (astly, any death allegations of residents to be reported to the reported to the registry by the hotification time.	notified e entangement harm, death,  dividual y conduct y staff at were intered the include s from sponders including etion adings. including dent abuse, I continue the Heattl ne required

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 18 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

# · · · · · · · · · · · · · · · · ·	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) D PLAN OF CORRECTION 1DENTIFICATION NUMBER: A, BUILDING					X3) DATE SURVEY  · COMPLETED	
		34G143	B, WING			l	C
		346143	D' 4404G			09/	22/2020
	ROMDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 149	Heimlich Maneuver. A laid him on his back a compressions until the Further review reveale	After that wasn't working, I	W	149	Completed day of Survey		Y12/2000
	disabilities profession following this incident there was no investiga staff. Further interview investigation into whe following DC #6's diet clients #1, #3 and #4. confirmed there was re clients #1, #3, #4 and	of DC#6 choking on 7/4/20, ation by facility management v confirmed there was no ther direct care staff were or the prescribed diets for Additional interview also no investigation whether	9	THE PARTY OF THE P			* ,
	12:09pm, client #1 was that was cut into half, grapes and a bag of c sandwich was not mo the sandwich and chippace of eating by the consumed the grapes	hips. The meat inside the dified. Client #1 consumed os with prompts to slow his					
	5:34pm, client #1 was about half inch pieces muffin. Client #1 used pieces of pork chop (s 1/4 inch) and carrots. muffin and ate it quick	on 9/21/20 of supper at served a pork chop cut into , cooked carrots and a corn his spoon to scoop up the several pieces were about He picked up the corn sly despite prompts to slow re were 2 direct care staff ining room.	при				

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 19 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

34G143 B. WING 09/22/2020	
	<b>2020</b>
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1722 ATHENS AVENUE  KEYWEST CENTER  DURHAM, NC 27707	· · · · · · · · · · · · · · · · · · ·
(FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI	(X5) OMPLETION DATE
W 149  During observations of breakfast on 9/22/20 at 6:27am, client #1 was served cut up french toast, patty sausage cut into helf, grifs and peaches (uncut in syrup). Client #1 quickly used his spoon to scoop the pieces of french toast and sausage into his mouth. There were 2 direct care staff and the QIDP in the dining room. Staff D verbally cued client #1 to slow his rate of consumption however, he consumed several large pieces of sausage and french toast before being redirected.  Review on 9/22/20 of client #1's individual program plan (IPP) dated 6/14/20 revealed he is prescribed a 2,000 calorie, chopped diet consistency due to the possibility of him overloading food during meals. Further review of the individual program plan (IPP) revealed client #1 is blind and requires complete physical assistance preparing his meals.  Review on 9/21/20 of client #1's nutritional evaluation dated 4/9/19 revealed client #1 requires "1:1 staffing due to his increased rate of eating to prevent choking. Additional review revealed his diet order is prescribed as a 2,000 calorie, chopped diet consistency.  2. During observations of lunch at 12:42pm, client #4 was served a turkey sandwich out into less than one fourth inch sections, chips and grapes. The QIDP prepared her lunch.  Review on 9/22/20 of client #4's IPP dated 5/14/20 revealed she is prescribed an 1800 calorie diet that is a blended ground consistency to reduce the possibility of choking. Fluids to be consumed before meals with Carnation Instant Breakfast twice daily.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 20 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO: 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CÒNS	TRUCTION		(X3) DATE SURVEY COMPLETED	
		34G143	8. WING				l	C 22/2020
NAME OF PI	CENTER			1722 AT	ADDRESS, CITY, STATE, ZIP COC HENS AVENUE NM, NC 27707	Œ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B E APPRÓPRIA		(X5) COMPLETION DATE
TAG W 149	Interview on 9/22/20 current diet orders for current. When asked training since the chorology of the diet orders for current. When asked shecific questic consistencies. Further were no models of via Additional interview of very attentive to clien modified consistency meals rapidly unless slow their rate of eating.  B. Facility Managemes supervise client #2 to of unauthorized access administration office stacility's computers.  Review of the facility' #2 on 9/21/20 revealed 1. On 2/20/20 at 11:0 conveyed that found room, with door crack computer.  2. On 3/22/20 at 4:15 coming out of the methat it had been broken.	with the QIDP revealed the clients #1 and #4 are about any recent training for which is incident for DC#6 on ferred to the dietician when ons regarding diet or interview revealed there sual cues for staff to follow, onfirmed that staff should be ts #1 and #4 as they require diets and consume their they are consistently cued to no.	W	149				
	bang, then saw client A noticed that the me	am, staff A heard a loud t #2 going to his room. Staff dication room had been e medication shelf had been		w./.datebases - page of the control				

FORM CMS-2587(02-99) Previous Versions Obsolete

Event (D: 1XKK11

Facility ID: 922086

If continuation sheet Page 21 of 37

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(	c
		34G143	B. WING			09/	22/2020
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 149	4. On 6/5/20 at 8:45 pround client #2 in the facility's computer. 5. On 7/16/20 at 5:12 intellectual development the medication robecause it was hot. The area, to walk up front #2 entered the medication key on the kitchen. Client #2 too medication key on the kitchen. Client #2 too medication room door interview on 9/22/20 took to the medication recently to try to previate.  Interview on 9/22/20 took to the medication room has prevent client #2's levent staff should check on Additional interview on Additional interview remedication room has prevent client #2 from room.  C. Staff C neglected client #5 was not subjunterview on 9/21/20 revealed he had over "B—" as he was leaving around the corner froof threw a glass of water on the floor. witness this but cames	om, the house manager medication room, using the pm, the assistant qualified ental professional (QIDP) om open to cool off, the assistant QIDP left the to talk with staff, when client ation room to access the am, staff A left the amat on the counter in the k the key and opened the rouse the computer.  with staff B stated that the room had to be changed ent client #2 from accessing with the QIDP when asked I of supervision revealed that the clients every hour, evealed the locks to the recently been changed to accessing the medication client #5 by failing to ensure	V	149			

FORM CMS-2557(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility (D: 922085

If continuation sheet Page 22 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIÉS CORRECTION	(X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		SURVEY PLETED
		34G143	8. WING		I	C /22/2020
	ROVIDER OR SUPPLIER		<b></b>	STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 149	#2 stated client #5 wito yell at staff for sevice Client #2 stated he did the QIDP.  Interview on 9/21/20 revealed she had be staff C and after yelling on her and called her with client #5 revealed incident to the QIDP.  Immediately after the 9/21/20 these allegat QIDP. The QIDP commade aware of these stated direct care stated intermal investigating an intermal investigating an intermal investigating return to work until a incident could be rearevealed client #5 ha inappropriate verbalia BSP was not followed.  Review on 9/21/20 of 2/19/20 revealed she deliberate verbal and Review of the facility and Neglect effective abuse is defined as: deprivation or physic. Baiting, teasing, scolor in a loud harsh ton	Id him what happened. Client as very upset and continued eral minutes afterwards, id not report this allegation to with client #5 in the facility come upset with direct careing at her, staff C threw water ra "B—." Further interviewed she did not report this assections were shared with the firmed she had not been allegations. The QIDP off C had not worked in the dwas not scheduled back to the stated she would begin into this incident by starting ion and that staff C would not conclusion about this ched. Additional interview da BSP to address zations, aggression and the	W 14			

FORM CMS-2567(02-99) Previous Versiona Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 23 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (DENTIFICATION NUMBER: A. BUILDING			X3) DATE SURVEY COMPLETED			
		34G143	B. WING			•	C 22/2020
NAME OF PI	CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 149	goals." Neglect is def which staff does not or responsibilities which negatively affect heal client. Neglect further to act spontaneously affect the health, safe Neglect, as opposed duties involves the farisk to client well-bein harm occurs or not."  After reviewing the aid determined facility mate thoroughly investig #6 as well as failed to training to direct care consistency diets for choking death of DC/conduct additional maconsistencies were formanagement staff fail staff treated clients were address client #2's supervision and failed support programs for These failures resulted of 5 clients and the posed an immediate facility.  The facility's plan to repopardy to the client.	with his/her therapeutic ined as: "Any situation in carry out duties or in turn has the potential to th, safety or well being of a refers to the failure of staff in any situation, which might by or well being of a client. It is negligent performance of illure to act when discernible ag is evident whether actual cove evidence, it was an agement staff neglected at the choking death of DC in provide any additional staff on modified 4 of 5 clients after the 6 and subsequently failed to eal monitoring to ensure diet bllowed as written. Facility led to ensure direct care ith dignity and respect, failed		149			
	modified diets. Impro	22, 2020 addressing all mptu training will be ng today's meal on all	етом натимающим макентальной				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 24 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' ' ' '		NSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G143	B. WNG				C 09/22/2020	
NAME OF PI	ROVIDER OR SUPPLIER			1722	ET ADDRESS, CITY, STATE. ZIP CODE ATHENS AVENUE HAM, NC 27707	***************************************		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE.	(X5) COMPLETION DATE	
W 149	modified diets. This was understand all client's All staff will have to co food modifications and their work assignment offered training they wimmediately until the plans were reviewed, needed.  Allegations of abuse clients will be investigation of abuse clients will be investigation is initiated completed in 5 working continue to address the unauthorized areas of Keywest Center has of changed locks, added added door lock strike in place safety measure those areas. We will a room medication keys Review was completed training that was proving that was proving their will be diet consistencies, sureporting allegations of mistreatment.  After reviewing the interviewing the intervie	rill ensure all staff is modified prescribed diets, complete training on all client d consistencies starting ts. If staff refuses to attend vill be suspended training is satisfied. All diet updated and modified as  or possible mistreatment of lated and addressed mated member of the Human It be responsible for assuring ed within 24 hours, and lag days. Keywest Center will line issues of clients if the home. To date, relocated staff computers, la computer passwords, la plates. Will continue to put ures that will prohibit entry to laiso secure the medication is."  ed on 9/22/20 of the video lided to the QIDPs. The g was discussed, and an erified. There was also an lare staff working in the dietary training on modified pervision of clients and		149				
	made by the surveyor	rs on site to remove the other of the clients in the facility.		o de la constante de la consta				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 25 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					i (;
		540 F43	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/2/2/2020
NAME OF PR	ROVIDER OR SUPPLIER			1722 ATHENS AVENUE	
KEYWEST	CENTER			DURHAM, NC 27707	
	<u> </u>				A. A.
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
TAG	REGULATORY OR I	,\$C IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
W 154	STAFF TREATMENT	OF CLIENTS	W 154	/	
	CFR(s): 483.420(d)(3			Completed Yaz/ar day of survey	74.6
				ound in the land of	
		e evidence that all alleged		day of survey	
	violations are thoroug	iniy investigated.			
		not met as evidenced by:			
		ews and interviews, the			
		igate the death of a client			
	due to choking and fa	niet to investigate nistreatment and abuse for 1			
	_	one deceased client (DC#6).			
	The findings are:			******	
	A THE AGA	16 to be allowed the			
		ent failed to thoroughly			
	) ***	of DC #6 after he choked at altime and died on 7/4/2020.			
	tito idomy acring ince	THE STATE STATE OF THE STATE OF			
	Review on 9/21/20 of	an incident report dated			
		evealed at a facility cookout			
		he table eating. Further			
	review indicates he w	ood from staff, staff caution	\$		
	_	ontinue to eat rapidly again			
		ow down, notice client	•		
		r immediately perform CPR			
		o facility, EMS arrived,			
		ent, no response unable to			
	revive client."				
	Further review on 9/2	1/20 of this incident report, a			
		nted, "I saw [DC#6] was	***************************************		
	choking so I proceede	ed to do the Heimlich	***************************************		
		wasn't working, I laid him on	Accessed 444	Tendente	
		chest compressions until the			
	, ·	Further review revealed no			
	Nurse or by facility m	ent report by the facility anagement staff		and the same of th	
	The state of the s	ner transport Estats se valuates .	***************************************	Acceptance	
	1		1	Į.	1

FORM CM5-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 28 of 37

PRINTEO: 09/30/2020 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A BUILDING		ESURVEY PLETED
		34G143	B. WING	······································	ı	C /22/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707		***
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		LD 8E	(X5) COMPLETION DATE
W 154	Review on 9/21/20 of Department of Health (DHHS) dated 7/9/20 facility due to an "acc County Police Depart Emergency Services follow up by facility m death report.  Review on 9/21/20 of was admitted on 6/27 diagnosed with a Sev and Autism Spectrum program plan (IPP) diagnosed with a Sev and Autism Spectrum program plan (IPP) diagnosed with a Sev and Autism Spectrum program plan (IPP) diagnosed with a Sev and Autism Spectrum program plan (IPP) diagnosed with a Sev and Carnatic Seakfast and Supper IPP indicated he fed if required chopped me and used an inner lip included putting one I		W	154		
	putting the second por Review on 9/21/20 of evaluation dated 8/24 prescribed a 2,000-2, portions and chopped indicated he was to be for food stealing behaviors as well as Review on 9/21/20 of program (BSP) dated target behaviors of phon-compliance, food	DC #6's nutritional //19 revealed DC #6 was 200 calorle diet with double if foods. Further review e monitored closely by staff avior and refrigerator raiding PICA.  DC #6's behavior support 8/24/19 revealed he had				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

if continuation sheet Page 27 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION,NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						C	
		34G143	B. WING_		<u> </u>	09/	22/2020
	ROVIDER OR SUPPLIER	,			TREET ADDRESS, CITY, STATE, ZIP CODE 722 ATHENS AVENUE		
KEYWES1	CENTER			E	DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X3) COMPLETION DATE
W 154	support program (BSI Celexa, Trazedone, C Melatonin.  Interview on 9/21/20 of disabilities profession received a phone call working at the facility choked during mealtir after EMS responded facility. Further intervisurveillance cameras areas and that the callincident had been rev Department and by he confirmed there was a surveillance footage.  Continued interview of wore statements by but no additional state who were interviewable there was no further in consistency food DC sitting with him at the from Durham County Department. When the conducted the investigation on an all QIDP.  Review on 9/21/20 of	P) incorporated the use of clonidine, Abilify and with the qualified intellectual al (QIDP) revealed she had from direct care staff on 7/4/20 that DC#6 had me and died at the facility to a choking incident at the ew confirmed there are in the facility in common mera footage for this iewed by the Durham Police erself. Additional interview no documentation of this with the QIDP revealed there out staff working on 7/4/20 ements from staff or clients le. The QIDP confirmed investigation into what #6 was served, who was table and no statements EMS or the Police in QIDP was asked who gation into DC #6's death, estigation was her	W	154			
		2 on 3/19/20, found in the led the following abuse					

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 28 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ADDITION NUMBER:  ADDITION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G143	B. WNG_		ı	C )/22/2020
	ROVIDER OR SUPPLIER T CENTER	<u> </u>		STREET ADDRESS, CITY, STATE, 2IP CODE 1722 ATHENS AVENUE DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			(X\$) COMPLETION DATE	
W 154	accusations about state "I do not like to be at comfortable thereM have beat me a lot exchristmas."  Interview with the QII the facility did not coron client #2's allegated did his own investigated did his own investigated the facility did not or reason the facility did designee to conduct to QIDP, who was accus DRUG USAGE CFR(s): 483.450(e)(2)  Drugs used for control client's individual progression of the behare employed.	aff:  t(facility), I do not feel  ls(QIDP) beat me. They  wen claims since last  DP on 9/22/20 revealed that induct an abuse investigation  on, because the psychlatrist  tion.  9/22/20 was present during acility's abuse investigations  ffer any explanation for the I not coordinate for a an investigation on the sed of abuse by client #2.  2)  DI of inappropriate behavior  gram plan that is directed the reduction of and eventual naviors for which the drugs  mot met as evidenced by: few and interview, the facility	W	The drug Hydroxi HCL 50MG was by the physicia The facility no 1	an. onger as for	
	management were no basis (PRN) for 1 of 5 findings is:	ot ordered on an as needed 5 (#2) audit clients. The standing PRN order for		any resident's inappropriate b	ehavior	924/ 12.020

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility IO: 922086

If continuation sheet Page 29 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION UNMBER: A, BUILDING			(X3) DATE SURVEY COMPLETED			
	34G143	B. WING_	B. WING			: 22/2020
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1722 ATHENS AVENUE DURHAM, NC 27707	DE	1 03/2	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD B E APPROPRI		(X5) COMPLETION DATE
Review on 9/21/20 of	the physician's orders,	Wa	312			
#2 revealed, an order (Hydroxyzine HCL 50 as needed if agitation repeat in 15 minutes mg/24 hours." An add 2020 Medication Adm documented that clier on 8/2/20.  Interview on 9/22/20 intellectual disabilities revealed that the facilibehavioral medication for PRN management DRUG STORAGE AN CFR(s): 483.460(I)(2)  The facility must keep locked except when by	was written to "take 1 tablet mg) by mouth as directed more then 2 minutes may if still upset. Maximum 100 ditional review of the August vinistration Record (MAR) at #2 received a PRN dose with the assistant qualified a professional (QIDP) ity was unaware that as should not be prescribed to fagitation.  ID RECORDKEEPING	W3	882			100
Based on record revifacility failed to ensure remained locked to profer 1 of 5 clients (clients). Staff failed to secure to the medication room vivial Review of the facility's #2 on 9/21/20 revealed.	ew and staff interviews, the e that the medication room event unauthorized access it #2). The finding is: the top and bottom doors to when not in use. s incident reports for client d the following concerns:					
	ROVIDER OR SUPPLIER  CENTER  SUMMARY ST. (EACH DEFICIENCE REGULATORY OR I  Continued From page Review on 9/21/20 of written 7/31/20 and re #2 revealed, an order (Hydroxyzine HCL 50 as needed if agitation repeat in 15 minutes mg/24 hours." An add 2020 Medication Adm documented that clien on 8/2/20.  Interview on 9/22/20 intellectual disabilities revealed that the facilibehavioral medication for PRN management DRUG STORAGE AN CFR(s): 483.460(I)(2)  The facility must keep locked except when be administration.  This STANDARD is repeated to ensure remained locked to provide facility failed to ensure remained locked to provide facility failed to secure the medication room with the redication r	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29  Review on 9/21/20 of the physician's orders, written 7/31/20 and renewed on 8/13/20 for client #2 revealed, an order was written to "take 1 tablet (Hydroxyzine HCL 50 mg) by mouth as directed as needed if agitation more then 2 minutes may repeat in 15 minutes if still upset. Maximum 100 mg/24 hours." An additional review of the August 2020 Medication Administration Record (MAR) documented that client #2 received a PRN dose on 8/2/20.  Interview on 9/22/20 with the assistant qualified intellectual disabilities professional (QIDP) revealed that the facility was unaware that behavioral medications should not be prescribed for PRN management of agitation.  DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(I)(2)  The facility must keep all drugs and biologicals locked except when being prepared for	ROVIDER OR SUPPLIER    CENTER	ROVIDER OR SUPPLIER  TOTAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTEYING INFORMATION)  COntinued From page 29  Review on 9/21/20 of the physician's orders, written 7/31/20 and renewed on 8/13/20 for client #2 revealed, an order was written to "take 1 tablet (Hydroxyzine HCL 50 mg) by mouth as directed as needed if agitation more then 2 minutes may repeat in 15 minutes if still upset. Maximum 100 mg/24 hours." An additional review of the August 2020 Medication Administration Record (MAR) documented that client #2 received a PRN dose on 8/2/20.  Interview on 9/22/20 with the assistant qualified intellectual disabilities professional (QIDP) revealed that the facility was unaware that behavioral medications should not be prescribed for PRN management of agitation.  DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2)  The facility must keep all drugs and biologicals locked except when being prepared for administration.  This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that the medication room remained locked to prevent unauthorized access for 1 of 5 clients (client #2). The finding is:  Staff failed to secure the top and bottom doors to the medication room when not in use.  Review of the facility's incident reports for client #2 on 9/21/20 revealed the following concerns:	ROWIDER OR SUPPLIER  34G143  STREET ADDRESS, CITY, STATE, ZIP GODE  1722 ATHENS AVENUE  DURHAM, NC 27T07  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  (SACH DEFICIENCY)  REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 29  Review on 9/21/20 of the physician's orders, written 7/31/20 and renewed on 8/13/20 for client #2 revealed, an order was written to "lake" I tablet (Hydroxyzine HCL 50 mg) by mouth as directed as needed if agitation more then 2 minutes may repeat in 15 minutes if still upset. Maximum 100 mg/24 hours." An additional review of the August 2020 Medication Administration Record (MAR) documented that client #2 received a PRN dose on 8/2/20.  Interview on 9/22/20 with the assistant qualified intellectual disabilities professional (CIDP) revealed that the facility was unaware that behavioral medications should not be prescribed for PRN management of agitation.  DRUG STORAGE AND RECORDICEPING CFR(s): 483.460(I)(2)  The facility must keep all drugs and biologicals tocked except when being prepared for administration.  This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that the medication room remained locked to prevent unauthorized access for 1 of 5 clients (client #2). The finding is:  Staff failed to secure the top and bottom doors to the medication room when not in use.  Review of the facility's incident reports for client #2 on 9/21/20 revealed the following concerns:	ROWDER OR SUPPLIER  346143  8. WING  STREETADDRESS, CITY, STATE, ZIP CODE  1722 ATHENS AVENUE  LURHAM, NC 27707  SLAMARY STATEMENT OF DERICLENDES BY FULL. RESULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29  Review on 9/21/20 of the physician's orders, written 7/31/20 and renewed on 8/13/20 for client #2 revealed, an order was written to "take 1 tablet (rhydroxyzine HCL. 50 mg) by mouth as directed as an ended if a glatation more then 2 minutes may repeat in 15 minutes if still upsat. Maximum 100 mg/24 hours. "An additional review of the August 2020 Medication Administration Record (MAR) documented that client #2 received a PRN dose on 8/2/20.  Interview on 9/22/20 with the assistant qualified intellectual disabilities professional (GIDP) revealed that the facility was unaware that behavioral medications should not be prescribed for PRN management of agitation.  CFR(s): 483.460(I)(2)  The facility must keep all drugs and biologicals locked except when being prepared for administration.  This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that the medication room remained locked to prevent unauthorized access for 1 of 5 clients (client #2). The finding is:  Staff failed to secure the top and bottom doors to the medication room when not in use.  Review of the facility's incident reports for client #2 on 9/21/20 revealed the following concerns:

FORM CMS-2567(02-99) Previous Versions Obsoléte

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 30 of 37

V-L11112		& MEDIOVID DELLAIDER			7 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
		1	M PERFECUENCES		:	<b></b>
		340143	9, WMG		1	J
i	AS ISSES AS ALIBERTES			TREET ADDRESS, CITY, STATE, ZIP CODE		22/2020
NAME OF P	ROVIDER OR SUPPLIER					
KEYWES	CENTER			722 ATHENS AVENUE DURHAM, NC 27707		
	<u> </u>					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 382	conveyed that four room, with door creamputer.  B. On 3/22/20 at 4 coming out of the state it had been brithe lock.  C. On 4/8/20 at 3.3 bang, then saw click A noticed that the stampered with and broken.  D. On 6/5/20 at 8:4 found client #2 in the facility's computer.  E. On 7/16/20 at 5 intellectual disability medication room on the computer.  F. On 7/29/20 at 8:4 medication room of kitchen. Client #2 the medication room of kitchen. Staff have aled that client access into the medication room of kitchen.	and client #2 in the medication acked, accessing the facility's 15 am, staff A saw client #2 medication room and noticed oken into, by tampering with 15 am, staff A heard a loud ent #2 going to his room. Staff medication room had been the medication shelf had been 15 pm, the residential manager he medication room, using the		In-service tromas held 10.10. Staff again wo Presented with Facility's protectives for some Medication story Keywest Key Proceedication call should always on the staff presidents, visit residents, visit	as the as and a the area of a	

FORM GMS-2587(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 31 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
and plan of	CURRECTION	Sharker ( ) [ [ ] 3 shifters a chief a s a may be been more as	A. BUILDING	ž	C	;
		34G143	B. WING		09/2	2/2020
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1722 ATHENS AVENUE DURHAM, NC 27707	)E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(XI) COMPLETION DATE
W 382 W 454	Interview on 9/21/20 client #2 used opport provided by staff, to greed cation room, who doors, and leaving the staff that they must key on their bodies. The lock to the door a prevent client #2 from room.  INFECTION CONTR CFR(s): 483.470(l)(1)  The facility must provided the province of the control of the	with the QIDP revealed that tunities inadvertently gain access to the sen staff did not lock the se area. She has instructed ock the door and keep the The facility has also changed and added a strike plate, to m breaking in the medication		a double bekists the installing of the installing of the of 9.22.2020 r theyordor occe occurred and the keys remains quarded by sta responsible for Odministration	1 Storage Lured Under tem includi a stike pla 10 other 25 tres 12 med 5 afe Liff Medication	
·	Based on observation failed to ensure the process-contamination potentially affected 6 Coronavirus pandern Staff failed to implem state mandated requiring the COVID-19 Throughout observation 3:27 pm-6:30 pwas observed to we chin leaving her mountain the coving her coving her mountain the coving her mountain the coving her covi	was prevented. This of 6 audit clients during the nic. The finding is: nent facility policy during a sirement to wear face masks	W45	Managements drive the stream and methods the emergency Preparedness goals are es Apolicy was with priorities the strategie Methods emy by managem	by which cy iniatives tablished	126/

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922085

If continuation sheet Page 32 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G143	B, WING	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	C 09/22/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVENUE DURHAM, NC 27707	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
W 454 W 459	mouth are covered at the state mandate to QIDP demonstrated staff as they enter the screening questions taken. Further intervishe did not have a wadditional interview on the entrance doo wear their masks who DIETETIC SERVICE CFR(s): 483,480	at all times in conjunction with a wear facial masks. The screening procedures for all me facility which includes and having their temperature view with the QIDP revealed written pandemic policy, revealed there is also a sign or that requires individuals to men entering the facility.		Specific performance in such as must wearing routine handwashing social distancing, en into the facility scredaily temperature chally routine healthough checks and daily routine of the chally route.	trance ening ecks, juestion outine
 W 460	The facility failed to their modified and sp (W460). This affecte and #5) in the facilit consistency diets.  The cumulative effect resulted in the facility statutorily mandated FOOD AND NUTRIT CFR(s): 483.480(a)(Each client must recovell-balanced diet in specially-prescribed.	Dietetic Services. FION SERVICES 1) seive a nourishing, adding modified and	W4 50	Residents continue to modified consistency In-service training in conducted regarding a resident receiving all consistency diet.  All residents modified and specifically prescribed diets a being served as individual dietan.	ans q.23.2020 any 10.10.2020 Hered 10.10.2020 Hered

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XXX11

F≱diity ID: 922086

If continuation sheet Page 33 of 37

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' ' '				SURVEY PLETED
		34G143	B. WING_			C /22/2020	
	ROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 722 ATHENS AVENUE URHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 460	clients (#1, #4 and #5 specially-prescribed of findings include:  A. Direct care staff fa meals on 9/21/20-9/2 and #5 received their as prescribed. For ex  1. During observation 12:09 pm, client #1 w that was cut into half, grapes and a bag of a sandwich was not mothe sandwich and chipace of eating by the intellectual disabilities consumed the grapes	illed to ensure 3 of 5 audit i) received modified and itiets as indicated. The illed to ensure for 4 observed 2/20 that clients #1 and #4 modified consistency diets ample: s on 9/21/20 of tunch at as served a turkey sandwich a small bag of whole chips. The meat inside the diffied. Client #1 consumed ps with prompts to slow his assistant qualified i professional (QIDP). He is quickly. The assistant	W	460			
	During observations of pm, client #1 was ser about half inch pieces muffin. Client #1 used pieces of pork chop (state) and sliced of up the corn muffin amprompts to slow his radirect care staff and the During observations of 6:27 am, client #1 was patty sausage cut into (uncut in syrup). Clie to scoop the pieces of into his mouth. There the QIDP in the dining	vere in the dining room.  on 9/21/20 of supper at 5:34  oved a pork chop cut into s, cooked carrots and a corn I his spoon to scoop up the several pieces were about cooked carrots. He picked d ate it quickly despite ate of eating. There were 2 are QIDP in the dining room.  of breakfast on 9/22/20 at as served cut up french toast, a half, grits and peaches at #1 quickly used his spoon af french toast and sausage awere 2 direct care staff and a room. Staff D verbally his rate of consumption					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 34 of 37

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTIÓN NG		(X3) DATE SURVEY COMPLETED	
		34G143	B. WING_			C 09/22/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2 4 1 3 4 1 1 2 1 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	
KEYWEST	CENTER			DURHAM, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 460	sausage and french to redirected.  Review on 9/22/20 of program plan (IPP) diprescribed a 2,000 care consistency due to the overloading food durithe individual program #1 is blind and require assistance preparing.  Review on 9/21/20 of evaluation dated 4/9/requires "1:1 staffing eating to prevent chorevealed his diet order calorie, chopped diet.  2. During observation client #4 was served less than one fourth in whole grapes. The Queriew on 9/22/20 of 5/14/20 revealed she calorie diet that is a bit or reduce the possibility.	ed several large pieces of oast before being  client #1's individual ated 5/14/20 revealed he is alorie, chopped diet e possibility of him ng meals. Further review of n plan (IPP) revealed client es complete physical his meals.  client #1's nutritional 19 revealed client #1 due to his increased rate of king." Additional review er is prescribed as a 2,000 consistency.  s of lunch at 12:42 pm, a turkey sandwich cut into nch sections, chips and IDP prepared her lunch.  client #4's IPP dated is prescribed an 1800 lended ground consistency ity of choking. Fluids to be als with Carnation Instant	W				
	current diet orders for current. When asked direct care staff in the she confirmed there is training since the cho	with the ChDP revealed the relients #1 and #4 are about any recent training for area of diet consistencies, has not been any additional king incident for DC #6 on erred to the dietician when					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 35 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

34G143 B, WING	C 09/22/2020
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1722 ATHENS AVENUE  DURHAM, NC 27707	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRED TO THE APP	BE COMPLETION
W 460 Continued From page 35 asked specific questions regarding diet consistencies. Further interview revealed there were no models of visual cues for staff to follow, however she did verify after talking with the dietician, grapes for a chopped diet should be sliced in half. Subsequent interview revealed ground diets should be prepared with a mechanical chopping device and have a smooth texture. Additional interview confirmed supplemental training was needed for direct care staff on diet consistencies.  Sandwich with a slice of funcheon meat and cheese, a package of large whole grapes, chips, small can of vegetable juice, and a can of soda. Client #6 was missing her to pand bottom front teeth and had trouble making small bites of the sandwich, due to the funcheon meat. She was observed biting into sandwich and needing to tug on the meat with her incisor teeth, which pulled the meat out of the sandwich, causing her to eat a larger portion of meat. After her meal, client #5 returned to the living room and had a few random coughs, as she watched television.  During the dinner observation of client #5 on 9/21/20 at 5:00 pm, she was served a whole baked pork chop, a cup of wild rice, cooked sliced carrots and had water and milk for her beverages. Client #5 used her knife and fork to cut up half of the pork chop, as staff stood by monitoring her actions. After make several 1/2" cuts into the meat, client #5 picked up the piece of the pork chop, attached to the bone and took a large bite with her teeth. Client #5 picked up the piece of the pork chop, attached to the bone and took a large bite with her teeth. Client #5 picked up the piece of the pork chop, attached to the bone and took a large bite with her teeth. Client #5 picked up the piece of the pork chop, attached to the bone and took a large bite with her teeth. Client #5 picked up the piece of the pork chop, attached to the bone and took a large bite with her teeth. Client #5 picked up the piece of the pork chop, attached to the bone and took a large bite with	

FORM GMS-2587(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 36 of 37

PRINTED: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  KEYWEST CENTER  SITHEET ADDRESS, CITY. STATE, JP CODE 1722 ATTEMS AVENUE DURHAM, NC 27707  PROVIDERS PLAN OF CORRECTION FREETY TAG  SUMMARY STATEMENT OF DEFICIENCIES FREETY TAG  SUMMARY STATEMENT OF DEFICIENCIES FREETY TAG  SUMMARY STATEMENT OF DEFICIENCIES FREETY TAG  CONTINUED FROM A SUPPLIER OF THE PROVIDERS PLAN OF CORRECTION FREETY TAG  W 460  Continued From page 36  W 460  W 460  Continued From page 36  W 460  W 460  W 460  Interview on 9/21/20 of client #5's Nutritional Evaluation dated /119/19 prescribed a 1800-2000 calories diet. Client #5's hould received chopped soft meats/soft cooked vegetables, no raw vegetables or fulls due to decline in chewing ability with missing testh. Client #5's had a tendency to eat too fast and should be monitored by staff during meals, with prompting to slow down pace of eating.  Interview with the QIDP on 9/22/20 revealed that she believed client #5' to be on a modified diet and that she was allowed to have whole grapes. A follow up interview with the ClIDP on 9/22/20 revealed that she had consulted with the dictician consultant and should have been serving client #5's chopped meat for meals, similar to chicken salad and that the grapes should be sliced in half.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION LOING		(X3) DATE SURVEY COMPLETED C	
NAME OF PROVIDER OR SUPPLIER  KEYWEST CENTER  SIREET ADDRESS, CITY, STATE, ZIP CODE 1722 ATHENS AVEBUE DURHAM, NC 27707  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 460  Continued From page 36  Review on 9/21/20 of client #5's Nutritional Evaluation dated 1/19/19 prescribed a 1800-2000 calories diet. Client #5 should received chopped soft meats/soft cooked vegetables, no raw vegetables or fruits due to decline in chewing ability with missing teeth. Client #5 had a tendency to eat too fast and should be monitored by staff during meals, with prompting to slow down pace of eating.  Interview with the QIDP on 9/22/20 revealed that she believed client #5 to be on a modified diet and that she was allowed to have whole grapes. A follow up interview with the QIDP on 9/22/20 revealed that she had consulted with the dietician consultant and should have been serving client #5 chopped meat for meals, similar to chicken			34G143	8. WING			1	
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  W 460  Continued From page 36  Review on 9/21/20 of client #5's Nutritional Evaluation dated 1/19/19 prescribed a 1800-2000 calories diet. Client #5 should received chopped soft meats/soft cooked vegetables, no raw vegetables or fruits due to decline in chewing ability with missing teeth. Client #5 had a tendency to eat too fast and should be monitored by staff during meats, with prompting to slow down pace of eating.  Interview with the QIDP on 9/22/20 revealed that she believed client #5 to be on a modified diet and that she was allowed to have whole grapes. A follow up interview with the QIDP on 9/22/20 revealed that she had consulted with the dietician consultant and should have been serving client #5 chopped meat for meals, similar to chicken					1722 ATHENS AVENUE			
Review on 9/21/20 of client #5's Nutritional Evaluation dated 1/19/19 prescribed a 1800-2000 calories diet. Client #5 should received chopped soft meats/soft cooked vegetables, no raw vegetables or fruits due to decline in chewing ability with missing teeth. Client #5 had a tendency to eat too fast and should be monitored by staff during meals, with prompting to slow down pace of eating.  Interview with the QIDP on 9/22/20 revealed that she believed client #5 to be on a modified diet and that she was allowed to have whole grapes. A follow up interview with the QIDP on 9/22/20 revealed that she had consulted with the dietician consultant and should have been serving client #5 chopped meat for meals, similar to chicken	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			X (EACH CORRECTIVE / CROSS-REFERENCED 1	(EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE		
	W 460	Review on 9/21/20 of Evaluation dated 1/19 calories diet. Client #4 soft meats/soft cooke vegetables or fruits de ability with missing te tendency to eat too faby staff during meals, down pace of eating.  Interview with the QIE she believed client #5 and that she was allo A follow up interview revealed that she had consultant and should #5 chopped meat for	client #5's Nutritional 2/19 prescribed a 1800-2000 5 should received chopped d vegetables, no raw ue to decline in chewing eth. Client #5 had a lest and should be monitored with prompting to slow  OP on 9/22/20 revealed that is to be on a modified diet wed to have whole grapes. with the QIDP on 9/22/20 it consulted with the dietician if have been serving client meals, similar to chicken	W	460			

FÖRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1XKK11

Facility ID: 922086

If continuation sheet Page 37 of 37

#### ===COVER PAGE===

TO: Esther Moore, Facility Compliance Consultant I

FAX: 919. 715. 8078

FROM: Keywest - Gwendolyn Johnson

TEL: 919.682.9392

DATE: <u>October 23, 2020</u>

PAGE[S] TO FOLLOW -38-

COMMENT:

The orginial documents mailed.

# KEYWEST CENTER, INC.

1722 Athens Avenue Durham, NC 27707 Phone: 919-682-9392

TONY BULLOCK
Administrator

GWENDOLYN JOHNSON QIDD/Assistant Administrator

October 23, 2020

Mental Health Licensure and Certification Section .
Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Recertification - Plan of Correction

Provider # 34G143 Mental Health #: 032-049

Intake: #NC00162457 and #NC00167330

#### Dear Ms. Moore:

Enclosed is the written plan of correction for the Keywest Center regarding deficiencies cited during the recertification visit conducted September 22, 2020.

This letter serves as our written request for a revisit. We have decided that November 3 thru November 6, 2020 will be made available to you to verify that all conditions cited have been corrected.

I further information or clarification is required contact us at the number listed above.

We will again expect to see you on your return.

Sincerely,

Tony Bullock Administrator

Enclosed: POC