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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G143	A. BUILDING _____ B. WING _____	C 09/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYWEST CENTER	1722 ATHENS AVENUE DURHAM, NC 27707

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E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach." (2) Include strategies for addressing emergency [illegible] *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency	E 006	The Keywest management reviewed and updated its Hazard Vulnerability Analysis (Hazards Risk Assessment). 10/2/20 [illegible] disasters in the North Central Region including the recent natural disasters (i.e. pandemic and earthquake) are addressed by policy, Procedure and Practices of Keywest Center. The emergency policy, Procedure and practices identifies designated Safe areas (i.e. fire-mailbox at driveways	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gwendolyn Johnson TITLE: QIDDP (X5) DATE: 10/23/2020

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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E 006	Continued From page 1 Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on policy review and interview, the facility failed to develop an emergency preparedness (EP) plan including and based upon a community and facility-based risk assessment utilizing an all-hazards approach. This had the potential to affect all clients, particularly during a Coronavirus pandemic. The finding is: The facility did not have an EP plan based on risk assessments. Review on 9/21/20 of the facility's current EP plan dated for 10/31/18, revealed the plan did not provide specific information in regards to a facility-based risk assessment utilizing an all-hazards approach. Interview on 9/21/20 with the qualified intellectual disabilities professional (QIDP), revealed that the facility had not obtained a facility-based risk assessment. Interview on 9/22/20 with the Administrator revealed that a risk assessment that focused on hurricanes did not effect their facility. The	E 006	entrance; tornado-Center protected Point of the facility without door and window access, bathroom #2). In Case of missing individual(s), staff's knowledge of resident's whereabouts in the group home, will allow them to locate and move residents to the designated safe area.	10/10/20

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	...continued from page 2			
	administrator acknowledged that they had not considered identifying other types of hazards to train staff.			
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop policy and procedures for sheltering in place in their emergency preparedness (EP) plan. This potentially affected all clients residing in the home. The finding is: The facility's EP plan did not address any plans to shelter in place during a pandemic response.	E 022	Keywest's management implemented and carried out a shelter in place plan authorized by the state, county and city government ordiance but it wasn't in writing. As of 9.26.2020, Keywest's management developed a written shelter in place plan for the COVID-19 pandemic as sanction by state government including local county-city government directives. 9/26/2020	

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E 022	Continued From page 3 Review on 9/21/20 of the facility's EP plan developed on 10/31/18 did not include language for situations that would call for the clients and staff to shelter in place. Interview on 9/22/20 with the qualified intellectual disabilities professional (QIDP), revealed that the facility had not incorporated a pandemic policy in their EP plan.	E 022		
E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other	E 025	Keywest's management will continue to carry out its emergency Preparedness accommodations agreement with Summerly Group Home. The current "Statement of Understanding Contract" (Accommodation Agreement) with Summerlyn Group Home dated 8.21.2019 is scheduled for renewal by 8.21.2021. 8.21.2019	

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E 025	Continued From page 4 [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. "[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on interviews and review of the facility's emergency preparedness (EP) plan, the facility failed to document pre-arranged accommodations for clients in the event services could not be delivered in the home. This potentially affected all clients in the home. The finding is: The facility failed to list emergency accommodations in their EP plan. Review on 9/21/20 of the facility's EP plan developed on 10/31/18 revealed that there was no listing of accommodations or arrangements for emergency purposes. Interview on 9/22/20 with staff B, revealed that when hired four months ago, he received training on fire drills but did not know where to take clients for emergency housing. Interview on 9/22/20 with the qualified intellectual disabilities professional, revealed that the facility could not produce an EP plan to inform staff where to take clients for emergency accommodations.	E 025		

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E 037	EP Training Program CFR(s): 483.475(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with	E 037	Keywest management will continue to implement awareness information engaging the attention of staff. Update training was conducted with new and existing staff on 10/10/2020. All emergency preparedness plans were reviewed, Per the emergency hazard. Staff were Presented with Varions disaster scenarios which required them to excute and emergency exercise.	10/10/2020

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E 037	Continued From page 6 procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency	E 037	Group discussion Provided staff an opportunity to address their techniques and consequences for unsatisfactory performance (i.e. fire, tornado, pandemic, ice storm, severe thunderstorm, and earthquake).	10/10/2020

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E 037	Continued From page 7 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected	E 037		

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E 037	Continued From page 8 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to conduct emergency preparedness (EP) plan training for staff annually and for new hires. This potentially affected all clients. The finding is: Staff did not receive EP plan training as required. Review on 9/21/20 of the facility's EP plan revealed that there was no evidence of current EP training for all staff. In the current manual, contained training sheets for staff from 2018. Furthermore, the names of the facility's newest employee was not documented as receiving EP training.	E 037		

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E 037	Continued From page 9 Interview on 9/22/20 with staff B, revealed that he had not received training on the EP plan policy since his hire four months ago. Interview on 9/22/20 with the assistant qualified intellectual disabilities professional (QIDP), revealed that she could not produce any current training for the EP plan policy. Interview on 9/22/20 with the QIDP, revealed that she did not conduct any training this year on the EP plan due to the Coronavirus pandemic.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or	E 039	The Keywest management Conducted exercises to test the identified risk hazards for the North Central Region under the direction of the QIDDP. Employees executed various emergency preparedness exercises which included resident participation. Management intends to implement systematic.	10/10/2020

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E 039	Continued From page 10 functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. "[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or	E 039	change and outcomes as needed that benefit and best serve the residents of Keywest center. The QIDDP facilitator conducted a full-scale exercise that was facility based which included a mock disaster drill and group discussion which was relevant to emergency preparedness initiatives	10/10/2020

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E 039	Continued From page 11 functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 12 (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: [illegible] is community-based, or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G143	A. BUILDING _____ B. WING _____	C 09/22/2020

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KEYWEST CENTER	1722 ATHENS AVENUE DURHAM, NC 27707

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E 039	Continued From page 13 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that	E 039		

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

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E 039	Continued From page 15 set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the	E 039		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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E 039	Continued From page 14 is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following; (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a	E 039		

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E 039	Continued From page 16 Review on 9/21/20 of the facility's EP plan developed on 10/31/18, did not include a full-scale community or tabletop exercise. Interview on 9/22/20 with staff B, revealed that after he was hired four months ago, he did not participate in any EP plan exercises. Interview on 9/22/20 with the qualified intellectual disabilities professional, revealed that she had not conducted any full-scale community or tabletop exercises this year because of the Coronavirus pandemic.	E 039		
W 000	INITIAL COMMENTS A recertification and complaint survey was completed on September 22, 2020 for Intakes #NC00162457 and NC00167330. Both complaints were substantiated. Deficiencies were cited in relation to the complaint intakes and the recertification survey.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibit mistreatment, neglect and abuse of the client (W149) and failed to thoroughly investigate allegations of abuse, neglect and mistreatment to clients (W154). The cumulative effect of these systemic practices resulted in the facility's failure to provide	W 122	Completed 9/22/2020 Since the most recent survey, Keywest management and staff have not encountered any life endangered incidents. Management conducted in-serving with its QP's and improved its guidelines for responding to life threatening situations as indicated.	

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

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W 122	Continued From page 17 statutorily mandated services of client protections to its clients.	W 122	The designated on-call person will return to the facility immediately when notified of any resident's life endangerment (i.e. stroke, suicidal harm, death, etc.). The designated individual shall immediately conduct an inquiry into the situation with all staff and residents that were involved or encountered the situation.	9/22/2020
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to assure its policies and procedures that prohibit neglect were implemented to prevent neglect for 4 of 5 clients (#1, #2, #4 and #5). One deceased client (DC #6) is also discussed in this finding. The findings are: A. Facility Management failed to retrain staff on modified consistency diets for 2 of 5 clients (#1 and #4) after (DC #6) choked during mealtime on 7/4/20 and subsequently died. For example: Review on 9/21/20 of an incident report dated 7/4/2020 at 4:30 pm revealed at a facility cookout DC #6 was sitting at the table eating. Further review indicates he was, "prompted about consuming to much food from staff, staff caution client twice, [DC #6] continue to eat rapidly again staff prompt him to slow down, notice client choking, staff member immediately perform CPR. 911 was dispatched to facility, EMS arrived, continue CPR on client, no response unable to revive client." Further review on 9/21/20 of this incident report revealed a second staff documented, "I saw (DC#6) was choking so I proceeded to do the	~~W 149~~	Management will include detailed documents from all emergency responders called to assist including staff's documentation in its report findings. Lastly, any death including allegations of resident abuse, neglect, etc. shall continue to be reported to the Health Care Registry by the required notification time period.	9/22/2020

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W 149	Continued From page 18 Heimlich Maneuver. After that wasn't working, I laid him on his back and started chest compressions until the paramedics arrived." Further review revealed no follow up on the incident report by the facility Nurse or by facility management staff. Interview on 9/21/20 with the qualified intellectual disabilities professional (QIDP) confirmed following this incident of DC#6 choking on 7/4/20, there was no investigation by facility management staff. Further interview confirmed there was no investigation into whether direct care staff were following DC #6's diet or the prescribed diets for clients #1, #3 and #4. Additional interview also confirmed there was no investigation whether clients #1, #3, #4 and DC #6 were being appropriately supervised during dining on 7/4/20. 1. During observations on 9/21/20 of lunch at 12:09pm, client #1 was served a turkey sandwich that was cut into half, a small bag of whole grapes and a bag of chips. The meat inside the sandwich was not modified. Client #1 consumed the sandwich and chips with prompts to slow his pace of eating by the assistant QIDP. He consumed the grapes quickly. The assistant QIDP and the QIDP were in the dining room. During observations on 9/21/20 of supper at 5:34pm, client #1 was served a pork chop cut into about half inch pieces, cooked carrots and a corn muffin. Client #1 used his spoon to scoop up the pieces of pork chop (several pieces were about 1/4 inch) and carrots. He picked up the corn muffin and ate it quickly despite prompts to slow his rate of eating. There were 2 direct care staff and the QIDP in the dining room.	W 149	Completed day of Survey	9/22/2020

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W 149	Continued From page 19 During observations of breakfast on 9/22/20 at 6:27am, client #1 was served cut up french toast, patty sausage cut into half, grits 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 5/14/20 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 cut 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.	W 149		

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W 149	Continued From page 20 Interview on 9/22/20 with the QIDP revealed the current diet orders for clients #1 and #4 are current. When asked about any recent training for [redacted] training since the choking incident for DC#6 on 7/4/20. The QIDP deferred to the dietician when asked specific questions regarding diet consistencies. Further interview revealed there were no models of visual cues for staff to follow. Additional interview confirmed that staff should be very attentive to clients #1 and #4 as they require modified consistency diets and consume their meals rapidly unless they are consistently cued to slow their rate of eating. B. Facility Management failed to adequately supervise client #2 to prevent repeated episodes of unauthorized access to the medication administration office so client #2 could access the facility's computers. Review of the facility's incident reports for client #2 on 9/21/20 revealed the following concerns: 1. On 2/20/20 at 11:05 am, direct care staff conveyed that found client #2 in the medication room, with door cracked, accessing the facility's computer. 2. On 3/22/20 at 4:15 am, staff A saw client #2 coming out of the medication room and noticed that it had been broken into, by tampering with the lock. 3. On 4/8/20 at 3:15 am, staff A heard a loud bang, then saw client #2 going to his room. Staff A noticed that the medication room had been tampered with and the medication shelf had been broken.	W 149		

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W 149	Continued From page 21 4. On 6/5/20 at 8:45 pm, the house manager found client #2 in the medication room, using the facility's computer. 5. On 7/16/20 at 5:12 pm, the assistant qualified intellectual developmental professional (QIDP) left the medication room open to cool off, because it was hot. The assistant QIDP left the area, to walk up front to talk with staff, when client #2 entered the medication room to access the computer. 6. On 7/29/20 at 8:10 am, staff A left the medication key on the mat on the counter in the kitchen. Client #2 took the key and opened the medication room door to use the computer. Interview on 9/22/20 with staff B stated that the lock to the medication room had to be changed recently to try to prevent client #2 from accessing it. Interview on 9/22/20 with the QIDP when asked about client #2's level of supervision revealed that staff should check on the clients every hour. Additional interview revealed the locks to the medication room has recently been changed to prevent client #2 from accessing the medication room. C. Staff C neglected client #5 by failing to ensure client #5 was not subjected to abuse. Interview on 9/21/20 with client #2 in the facility revealed he had overheard staff C call client #5 a "B—" as he was leaving the shower located around the corner from the kitchen area, staff C threw a glass of water on her and there was a lot of water on the floor. Client #2 stated he did not witness this but came out of the bathroom, heard client #5 yelling and saw water on the floor. Client	W 149		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 22 #2 stated client #5 told him what happened. Client #2 stated client #5 was very upset and continued to yell at staff for several minutes afterwards. Client #2 stated he did not report this allegation to the QIDP. Interview on 9/21/20 with client #5 in the facility revealed she had become upset with direct care staff C and after yelling at her, staff C threw water on her and called her a "B—." Further interview with client #5 revealed she did not report this incident to the QIDP. Immediately after these client interviews on 9/21/20 these allegations were shared with the QIDP. The QIDP confirmed she had not been made aware of these allegations. The QIDP stated direct care staff C had not worked in the facility on 9/21/20 and was not scheduled back to work until 9/23/20. She stated she would begin immediately looking into this incident by starting an internal investigation and that staff C would not return to work until a conclusion about this incident could be reached. Additional interview revealed client #5 had a BSP to address inappropriate verbalizations, aggression and the BSP was not followed. Review on 9/21/20 of client #5's BSP dated for 2/19/20 revealed she has target behaviors of deliberate verbal and physical aggression. Review of the facility's policy #00028 on Abuse and Neglect effective 1/1990 revealed emotional abuse is defined as: "Threatening punishment, deprivation or physical violence in any form. Baiting, teasing, scolding using profane language or in a loud harsh tone of voice or acting in any manner designed to humiliate a person in any	W 149		

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W 149	Continued From page 23 manner inconsistent with his/her therapeutic goals." Neglect is defined as: "Any situation in which staff does not carry out duties or responsibilities which in turn has the potential to negatively affect health, safety or well being of a client. Neglect further refers to the failure of staff to act spontaneously in any situation, which might affect the health, safety or well being of a client. Neglect, as opposed to negligent performance of duties involves the failure to act when discernible risk to client well-being is evident whether actual harm occurs or not." After reviewing the above evidence, it was determined facility management staff neglected to thoroughly investigate the choking death of DC #6 as well as failed to provide any additional training to direct care staff on modified consistency diets for 4 of 5 clients after the choking death of DC#6 and subsequently failed to conduct additional meal monitoring to ensure diet consistencies were followed as written. Facility management staff failed to ensure direct care staff treated clients with dignity and respect, failed to address client #2's repeated lack of supervision and failed to follow the behavior support programs for clients #2 and #5 as written. These failures resulted in the systemic neglect of 4 of 5 clients and the team on site verified this posed an immediate jeopardy to the clients in the facility. The facility's plan to remove the immediate jeopardy to the clients dated 9/22/20 included: [illegible] Tuesday September 22, 2020 addressing all modified diets. Impromptu training will be provided to staff during today's meal on all	W 149		

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W 149	Continued From page 24 modified diets. This will ensure all staff understand all client's modified prescribed diets. All staff will have to complete training on all client food modifications and consistencies starting their work assignments. If staff refuses to attend offered training they will be suspended immediately until the training is satisfied. All diet plans were reviewed, updated and modified as needed. Allegations of abuse or possible mistreatment of clients will be investigated and addressed immediately. A designated member of the Human Rights Committee will be responsible for assuring investigation is initiated within 24 hours, and completed in 5 working days. Keywest Center will continue to address the issues of clients unauthorized areas of the home. To date, Keywest Center has relocated staff computers, changed locks, added computer passwords, added door lock strike plates. Will continue to put in place safety measures that will prohibit entry to those areas. We will also secure the medication room medication keys." Review was completed on 9/22/20 of the video training that was provided to the QIDPs. The material in this training was discussed, and an inservice sheet was verified. There was also an interview with direct care staff working in the facility regarding the dietary training on modified diet consistencies, supervision of clients and reporting allegations of abuse, neglect and mistreatment. After reviewing the information that the facility provided on 9/22/20 at 6:30 pm a decision was made by the surveyors on site to remove the immediate jeopardy to the clients in the facility.	W 149		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	343143	B. WING	09/22/2020

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W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to investigate the death of a client due to choking and failed to investigate allegations of client mistreatment and abuse for 1 of 5 clients (#2) and one deceased client (DC#6). The findings are: A. Facility management failed to thoroughly investigate the death of DC #6 after he choked at the facility during mealtime and died on 7/4/2020. Review on 9/21/20 of an incident report dated 7/4/2020 at 4:30 pm revealed at a facility cookout DC #6 was sitting at the table eating. Further review indicates he was, "prompted about consuming to much food from staff, staff caution client twice, [DC#6] continue to eat rapidly again staff prompt him to slow down, notice client choking, staff member immediately perform CPR 911 was dispatched to facility, EMS arrived, Continue CPR on client, no response unable to revive client." Further review on 9/21/20 of this incident report, a second staff documented, "I saw [DC#6] was choking so I proceeded to do the Heimlich Maneuver. After that wasn't working, I laid him on his back and started chest compressions until the paramedics arrived." Further review revealed no follow up on the incident report by the facility Nurse or by facility management staff.	W 154	Completed 9/22/2020 day of survey	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G143	A. BUILDING _____ B. WING _____	C 09/22/2020

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W 154	Continued From page 26 Review on 9/21/20 of a death report to the Department of Health and Human Services (DHHS) dated 7/9/20 indicated DC #6 died at the facility due to an "accident" and that the Durham County Police Department and Durham County Emergency Services were involved. There is no follow up by facility management noted on the death report. Review on 9/21/20 of DC#6's record revealed he was admitted on 6/27/15 and that he had been diagnosed with a Severe Intellectual Disability and Autism Spectrum Disorder. His individual program plan (IPP) dated 8/25/18 revealed he was ambulatory and had limited communication skills. Further review of his IPP revealed he was prescribed a 2,000-2,200 calorie diet with double portions and Carnation Instant breakfast at Breakfast and supper. Additional review of the IPP indicated he fed himself independently, he required chopped meats, soft cooked vegetables and used an inner lip plate. Staff instructions included putting one half of his food portion on his plate and then after that amount was consumed, putting the second portion on his plate. Review on 9/21/20 of DC #6's nutritional evaluation dated 8/24/19 revealed DC #6 was prescribed a 2,000-2,200 calorie diet with double portions and chopped foods. Further review indicated he was to be monitored closely by staff for food stealing behavior and refrigerator raiding behaviors as well as PICA. Review on 9/21/20 of DC #6's behavior support program (BSP) dated 8/24/19 revealed he had target behaviors of physical aggression, non-compliance, food grabbing, refrigerator raiding and physically acting out. His behavior	W 154		

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	34G143	A. BUILDING _____ B. WING _____	C 09/22/2020

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W 154	Continued From page 27 support program (BSP) incorporated the use of Celexa, Trazedone, Clonidine, Abilify and Melatonin. Interview on 9/21/20 with the qualified intellectual disabilities professional (QIDP) revealed she had received a phone call from direct care staff working at the facility on 7/4/20 that DC#6 had choked during mealtime and died at the facility after EMS responded to a choking incident at the facility. Further interview confirmed there are surveillance cameras in the facility in common areas and that the camera footage for this incident had been reviewed by the Durham Police Department and by herself. Additional interview confirmed there was no documentation of this surveillance footage. Continued interview with the QIDP revealed there were statements by both staff working on 7/4/20 but no additional statements from staff or clients who were interviewable. The QIDP confirmed there was no further investigation into what consistency food DC #6 was served, who was sitting with him at the table and no statements from Durham County EMS or the Police Department. When the QIDP was asked who conducted the investigation into DC #6's death, she confirmed the investigation was her responsibility. B. Facility management did not conduct an abuse investigation on an allegation made against the QIDP. Review on 9/21/20 of a Follow-Up Form from psychiatry for client #2 on 3/19/20, found in the medical chart, contained the following abuse	W 154		

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W 154	Continued From page 28 accusations about staff: " I do not like to be at ___ (facility), I do not feel comfortable there...Ms. ___(QIDP) beat me. They have beat me a lot even claims since last Christmas." Interview with the QIDP on 9/22/20 revealed that the facility did not conduct an abuse investigation on client #2's allegation, because the psychiatrist did his own investigation. The Administrator on 9/22/20 was present during a discussion on the facility's abuse investigations in 2020. He did not offer any explanation for the reason the facility did not coordinate for a designee to conduct an investigation on the QIDP,who was accused of abuse by client #2.	W 154		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure drugs used for behavioral management were not ordered on an as needed basis (PRN) for 1 of 5 (#2) audit clients. The findings is: Facility maintained a standing PRN order for client #2's behavioral medication.	W 312	The drug Hydroxyzine HCL 50MG was [illegible] by the physician. The facility no longer uses control drugs for any resident's inappropriate behavior.	9/24/2020

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	34G143	A. BUILDING _____ B. WING _____	C 09/22/2020

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W 312	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.	W 312		
W 382	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: A. On 2/20/20 at 11:05 am, staff (not on survey)	W 382		10/10/2020

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
	34C143	B. WING	C 09/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 382	Continued From page 30 conveyed that found client #2 in the medication room, with door cracked, accessing the facility's computer. B. On 3/22/20 at 4:15 am, staff A saw client #2 coming out of the medication room and noticed that it had been broken into, by tampering with the lock. C. On 4/8/20 at 3:15 am, staff A heard a loud bang, then saw client #2 going to his room. Staff A noticed that the medication room had been tampered with and the medication shelf had been broken. D. On 6/5/20 at 8:45 pm, the residential manager found client #2 in the medication room, using the facility's computer. E. On 7/16/20 at 5:12 pm, the assistant qualified intellectual disabilities professional (QIDP) left the medication room open to cool off, because it was hot. The assistant QIDP left the area, to walk up front to talk with staff, when client #2 entered the medication room to access the computer. F. On 7/29/20 at 8:10 am, staff A left the medication key on the mat on the counter in the kitchen. Client #2 took the key and opened the medication room door, to use the computer. Interview on 9/22/20 with staff B stated that the lock to the medication room had to be changed recently, to try to prevent client #2 was accessing it. Interview on 9/21/20 with the assistant QIDP revealed that client #2 will try any measure to gain access into the medication room, so that he can use the computer for unauthorized use. Since the incidents, staff have been told to keep the medication room locked and to maintain contact with the key.	W 382	In-service training was held 10.10.2020. Staff again was Presented with the facility's protocol and Practices for safeguarding med keys and the Medication storage area. Keywest key protocol— keys to the medication door entrance and Medication cabinets should always be kept on the staff person responsible for medication administration. They should never be left accesible to residents, visitor, etc.	

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

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W 382	Continued From page 31 Interview on 9/21/20 with the QIDP revealed that client #2 used opportunities inadvertently provided by staff, to gain access to the medication room, when staff did not lock the doors, and leaving the area. She has instructed staff that they must lock the door and keep the key on their bodies. The facility has also changed the lock to the door and added a strike plate, to prevent client #2 from breaking in the medication room.	W 382	The medication storage area remains secured under a double lock system including the installing of a strike plate. As of 9.22.2020 no other key or door access has occurred and the med keys remains safe guarded by staff responsible for medication administration.	
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure the potential for cross-contamination was prevented. This potentially affected 6 of 6 audit clients during the Coronavirus pandemic. The finding is: Staff failed to implement facility policy during a state mandated requirement to wear face masks during the COVID-19 pandemic. Throughout observations on 9/21/20 at the facility from 3:27 pm-6:30 pm the residential manager was observed to wear her facial mask below her chin leaving her mouth and nasal passages exposed. Interview on 9/22/20 with the qualified intellectual disabilities professional (QIDP) revealed direct care staff should consistently be wearing masks in the facility so that their nasal passages and	W454	Management's priorities drive the strategies and methods by which the emergency Preparedness initiatives goals are established. A policy was developed with priorities driving the strategies and Methods employed by management.	9/24/2020

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W 454	Continued From page 32 mouth are covered at all times in conjunction with the state mandate to wear facial masks. The QIDP demonstrated screening procedures for all staff as they enter the facility which includes screening questions and having their temperature taken. Further interview with the QIDP revealed she did not have a written pandemic policy. Additional interview revealed there is also a sign on the entrance door that requires individuals to wear their masks when entering the facility.	W 454	Specific performance indicators such as mask wearing, routine handwashing, social distancing, entrance into the facility screening, daily temperature checks, daily routine health question checks and daily routine disinfecting of the group home.	9/26/2020
W 459	DIETETIC SERVICES CFR(s): 483.480 The facility must ensure that specific dietetic services requirements are met. This CONDITION is not met as evidenced by: The facility failed to: ensure each client received their modified and specially-prescribed diets (W460). This affected 3 of 5 audit clients (#1, #4 and #5) in the facility who received modified consistency diets. The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated Dietetic Services.	~~W 459~~ W459	Residents continue to receive modified consistency diets In-service training was conducted regarding any resident receiving altered Consistency diet.	9.22.2020 9.23.2020 10.10.2020
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record	W 460	All residents modified and specifically prescribed diets are being served as indicated by their individual diet plan.	9.22.2020

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W 460	Continued From page 33 reviews, the facility failed to ensure 3 of 5 audit clients (#1, #4 and #5) received modified and specially-prescribed diets as indicated. The findings include: A. Direct care staff failed to ensure for 4 observed meals on 9/21/20-9/22/20 that clients #1 and #4 and #5 received their modified consistency diets as prescribed. For example: 1. During observations on 9/21/20 of lunch at 12:09 pm, client #1 was served a turkey sandwich that was cut into half, a small bag of whole grapes and a bag of chips. The meat inside the sandwich was not modified. Client #1 consumed the sandwich and chips with prompts to slow his pace of eating by the assistant qualified intellectual disabilities professional (QIDP). He consumed the grapes quickly. The assistant QIDP and the QIDP were in the dining room. During observations on 9/21/20 of supper at 5:34 pm, client #1 was served a pork chop cut into about half inch pieces, cooked carrots and a corn muffin. Client #1 used his spoon to scoop up the pieces of pork chop (several pieces were about 1/4 inch) and sliced cooked carrots. He picked up the corn muffin and ate it quickly despite prompts to slow his rate of eating. There were 2 direct care staff and the QIDP in the dining room. During observations of breakfast on 9/22/20 at 6:27 am, client #1 was served cut up french toast, patty sausage cut into half, grits 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	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 460	Continued From page 34 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 5/14/20 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 12:42 pm, client #4 was served a turkey sandwich cut into less than one fourth inch sections, chips and whole 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. Interview on 9/22/20 with the QIDP revealed the current diet orders for clients #1 and #4 are current. When asked about any recent training for direct care staff in the area of diet consistencies, she confirmed there has not been any additional training since the choking incident for DC #6 on 7/4/20. The QIDP deferred to the dietician when	W 460		

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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 luncheon meat and cheese, a package of large whole grapes, chips, small can of vegetable juice, and a can of soda. Client #5 was missing her top and bottom front teeth and had trouble making small bites of the sandwich, due to the luncheon 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 consumed all of her food and drinks. Afterwards, client #5 watched television and could be heard making a few random coughs.	W 460		

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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 salad and that the grapes should be sliced in half.	W 460		

===COVER PAGE===

TO: Esther Moore, Facility Compliance Consultant I

FAX: 919.715.8078

FROM: Keywest - Gwendolyn Johnson

TEL: 919.682.9392

DATE: October 23, 2020

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

Tony Bullock
Administrator

Enclosed: POC