STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure client #2 was afforded privacy during personal care. This affected 1 of 6 audit clients. The finding is: During observations in the home on 1/12/21 at 7:32am, client #2 was observed in the shower. Staff D was bathing client #2 with the bathroom door open, and client #2 could be seen from the hallway in the reflection of the mirror standing in the shower. Further observations at 7:34am revealed client #2 standing in the middle of the bathroom, completely undressed, with Staff D using a towel to dry him off. During the time client #2 was in the bathroom, his peer was walking in and out of his bedroom that is located directly across the hall from the bathroom. At no time was client #2 prompted to close the bathroom door nor did staff close the door. Review on 1/12/21 of client #2's individual program plan (IPP) dated 4/5/20 did not reveal a strength or need in the area of closing the door for privacy. Additional review on 1/12/21 of client #2's record revealed an Activities of Daily Living Assessment dated 4/1/20. The Activities of Daily Living Assessment's area for closing the door for privacy was not completed in order to identify a strength or need in this area.	W 130	A review of systems revealed that although staff have been previously trained on consumer privacy and there are policies in place to address consumer privacy, there is a continued need to provide additional training to staff in this area based on the annual survey findings at our Kenwood Group Home. As a result of this deficiency, all staff will receive training on consumer privacy by 2/28/2021 provided by the Qualified Professional or ICF Program Director. The QP will provide at least monthly monitoring to ensure that consumer privacy needs are being met. Additionally, the consumer's IPP will be reviewed to discuss whether there is a need to include a privacy goal in the consumer's individual program plan. After completion of the annual survey and following receipt of the plan of correction, we found it best to sever ties with the ICF QP. We have hired a seasoned QP who previously served in the ICF QP role prior to her current appointment as DDA Program Director/QP. She will be working with the survey team and staff moving forward to oversee the implementation of the plan of correction.	Within 60 days of approval of plan of correction

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cathy S. Harris | TITLE: Program Director, Qualified Professional | (X6) DATE: 1/30/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 130	Continued From page 1 Interview on 1/12/21 with the Qualified Intellectual Disabilities Professional (QIDP) and the Home Manager (HM) confirmed that staff should verbally prompt client #2 to close the door and if he doesn't, staff should close it.	W 130		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to ensure the qualified intellectual disability professional (QIDP) coordinated, integrated and monitored active treatment for 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). The findings are: A. Review on 1/12/21, revealed that the facility failed to update the current individual program plan (IPP) for 5 of 6 audit clients (#1, #3, #4, #5 and #6). Interview on 1/11/21 with the QIDP revealed that she had current IPPs on a thumb drive that was located at her office and she would bring the updated IPP to the facility on 1/12/21. Additional interview on 1/12/21 with the QIDP revealed no updated IPP were available. B. Throughout the survey on 1/11/21 through 1/12/21, all clients in the home were observed to sit in the living room, sit in their bedrooms, and sit and/or lay on the couch in the activity room. During the observations, staff were observed to sit in the living room watching television or use	W 159	Following completion of the January 11-12, 2021 group home survey, a review of systems determined that the ICF QP was not following the policies regarding the requirements for completing the annual review and updating of consumer IPP. Due to the nature of this deficiency, we have determined it best to sever ties with the current QP. We have coordinated with the previous ICF QP (current DDA Program Director/QP) to review and update all consumer IPP, BSP, and consents. Over the next 45 days, the QP will work to coordinate with each guardian to schedule annual program plan meetings and update all IPP and consents. The QP will create an updated annual program schedule and provide to all consultants as well as provide guardians with annual program letters of their upcoming program meetings. In addition to the above, the systems review revealed deficiencies surrounding active treatment. As a result of this deficiency, all staff will receive additional training on active treatment provided by the QP or Program Director. Furthermore, staff will receive written counseling on the Autism Services, Inc. cellphone use policy. The group home lead staff will work closely with the Qualified Professional to complete the monthly activity calendar and will be required to submit the monthly plan to the Qualified Professional prior to the end of the current month.	February 26, 2021 February 26, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 2 their personal cell phones. There were minimum interactions from staff to prompt or encourage the clients to actively participate in any form of active treatment. Interview on 1/12/21 with the Home Manager (HM) revealed that he recently returned from a two month extended leave yesterday. The HM stated that typically, the QIDP is responsible for coordinating client services during the HM's absence. On 1/11/21, he discovered that activities for January had not been planned. C. Review on 1/12/21 of clients #1, #2, #3, #4, #5 and #6's data collections on their formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review. Interview on 1/12/21 with the QIDP revealed that she is sure staff are documenting data on training objectives and programs, and there must be a glitch in the system as to why no data is available. The QIDP confirmed that if no data is documented, it was not done D. Review on 1/12/21 revealed the facility failed to ensure the restrictive behavior techniques which included the use of psychotropic medication for 3 of 6 audit clients (#1, #2 and #6) was reviewed and monitored by the human rights committee (HRC). Interview on 1/12/21 with the Program Director (PD) revealed if no written review or consent by the HRC was available for review in client #1, #2 and #6's record, they were not obtained. E. Review on 1/12/21, revealed the facility failed	W 159	C. A review of systems revealed that although policies are in place to address the requirements for documentation of consumer goals, there is a continued need to improve staff understanding of how and where to document consumer goals. After reviewing through the EHR system, the QP found that the documentation was entered into the wrong areas of the EHR system for the months in question. This revealed the need to review the goals and objectives in the EHR system, update the documentation online, and provide additional training to staff on how to enter documentation into the system. With the help of our agency technical support, the QP will work to update all program data in the EHR system and provide training to staff within 45 days of approval of the plan of correction. D. Following completion of the January 11-12, 2021 group home survey, a review of systems determined that the ICF QP was not following the policies regarding the requirements for submitting all BSPs to HRC for annual review. As a result, the QP has requested copies of the most recent BSP for each consumer from the psychologist and will present them to the HRC for review. Within 45 days of approval of the Plan of Correction, the QP will create a document that details the date for each consumer's BSP renewal and reviewed on date to ensure that BSP remain current.	February 26, 2021 February 26, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 3 to ensure written informed consent was obtained for clients restrictive Behavior Intervention Plans (BIP). This affected 3 of 6 audit clients (#1, #2 and #6). Interview on 1/12/21 with the QIDP confirmed that she had not obtained written consent for client #1, #2 and #6. Interview on 1/12/21 with the PD revealed that she had concerns that the QIDP was not spending sufficient time in the home, monitoring staff and client services. The PD acknowledged that if the QIDP was not able to produce documentation that IPP's, BIP's, HRC and guardian consents were done, as the QIDP indicated, then the work was likely incomplete.	W 159	E. Following the annual survey, the systems review revealed that the ICF QP was not following policy regarding the requirement to obtain guardian consent for BSPs at least annually. As a result, the QP has requested copies of the most recent BSP for each consumer from the psychologist and will review the BSP with the guardian prior to obtaining consent. Within 45 days of approval of the Plan of Correction, the QP will create a document that details the date for each consumer's BSP renewal date to monitor monthly to ensure that BSP are received, reviewed with the guardian, and signed by the guardian annually.	February 26, 2021
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The team failed to: ensure that each client received a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training and treatment directed towards the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible (W196 and W249), ensure objectives are developed necessary to meet the client's needs (W227), ensure data relative to the accomplishment of the criteria specified in client individual program plan	W 195	Following completion of the January 11-12, 2021 group home survey, a review of systems determined that the ICF QP was not following the policies regarding the requirements for completing the annual review and updating of consumer IPP. Due to the nature of this deficiency, we have determined it best to sever ties with the current QP. We have coordinated with the previous ICF QP (current DDA Program Director/QP) to review and update all consumer IPP, BSP, and consents. Over the next 45 days, she will work to coordinate with each guardian to schedule annual program plan meetings and update all IPP and consents. The QP will create an updated annual program schedule and provide to all consultants as well as provide guardians with annual program letters of their upcoming program meetings. The QP has requested copies of each consumer's BSP and will review each consumer's BSP with the guardian and submit to HRC for approval. In addition to the above, the systems review revealed deficiencies surrounding active	February 26, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 195	Continued From page 4 objectives are documented in measurable terms (W252), ensure the client's individual program plan is reviewed and revised annually (W260), ensure that client's individual program plan with restrictions is reviewed, approved and monitored by the Human Rights Committee (W262), and ensure that client's individual program plans are conducted with written informed consent (W263). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to the clients.	W 195	cont'd from page 4 treatment. As a result of this deficiency, all staff will receive additional training on active treatment provided by the QP or Program Director. The group home lead staff will work closely with the Qualified Professional to complete the monthly activity calendar and will be required to submit the monthly plan to the Qualified Professional prior to the end of the current month.	
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the team failed to assure that a continuous aggressive active treatment program was implemented for 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6) which provided consistent implementation of the individual program plan (IPP) and interventions in the facility, which promoted client function with as much	W 196	Following completion of the January 11-12, 2021 group home survey, a review of systems determined that the ICF QP was not following the policies regarding the requirements for completing the annual review and updating of consumer IPP. Due to the nature of this deficiency, we have determined it best to sever ties with the current QP. We have coordinated with the previous ICF QP (current DDA Program Director/QP) to review and update all consumer IPP, BSP, and consents. Over the next 45 days, she will work to coordinate with each guardian to schedule annual program plan meetings and update all IPP and consents. The QP will create an updated annual program schedule and provide to all consultants as well as provide guardians with annual program letters of their upcoming program meetings. After reviewing through the EHR system, the QP found that the documentation was entered into the wrong areas of the EHR system for the months in question. This revealed the need to review the goals and objectives in the EHR system, udpate the documentation online, and provide	February 26, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	Continued From page 5 independence as possible and prevented regression of acquired skills. The findings are: A. Cross reference W227. The facility failed to ensure the IPP included guidelines to address identified needs relative to behavior management for 1 of 6 audit clients (#2). B. Cross reference W249. The facility failed to ensure 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the IPP. C. Cross reference W252. The facility failed to ensure data relative to the accomplishment of objective criteria was documented in measurable terms. This affected 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). D. Cross reference W260. The facility failed to update the current IPP for 5 of 6 audit clients (#1, #3, #4, #5 and #6). E. Cross reference W262. The facility failed to ensure the restrictive behavior techniques which included the use of psychotropic medication for 3 of 6 audit clients (#1, #2 and #6) was reviewed and monitored by the human rights committee (HRC). F. Cross reference W263. The facility failed to ensure written informed consent was obtained for clients restrictive Behavior Intervention Plans (BIP). This affected 3 of 6 audit clients (#1, #2 and #6).	W 196	cont'd. from page 5 additional training to staff on how to enter documentation into the system. With the help of our agency technical support, the QP will work to update all program data in the EHR system and provide training to staff within 45 days of approval of the plan of correction. Furthermore, the QP will review consumer progress on goals with the IDT team during the monthly IDT meeting and include the progress for each goal in the monthly QP note to be included in the consumer's permanent record book. The QP has requested copies of each consumer's BSP and will review each consumer's BSP with the guardian and submit to HRC for approval. In addition to the above, the systems review revealed deficiencies surrounding active treatment. As a result of this deficiency, all staff will receive additional training on active treatment provided by the QP or Program Director. The group home lead staff will work closely with the Qualified Professional to complete the monthly activity calendar and will be required to submit the monthly plan to the Qualified Professional prior to the end of the current month.	
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)	W 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 227	Continued From page 6	W 227		
	The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.			
	This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure the individual program plan (IPP) included training to address identified needs relative to behavior management for 1 of 6 audit clients (#2). The finding is: During observations in the home on 1/11/21, client #2 was observed to walk out of the activity room, through the living room and into the dining room. Client #2's genitals were hanging out of the top of his pants. Additional observations in the home on 1/11/21 at 4:52pm revealed client #1, client #2 and client #3 in the activity room. Client #1 and client #3 were sitting in chairs, while client #2 was laying on the couch watching an iPad. Client #2 had his genitals out of his pants and was stimulating himself. Review on 1/12/21 of client #2's individual program plan (IPP) dated 4/5/20 did not reveal an identified need to address the behavior of self stimulation or pulling his genitals out in public areas. Additional review of client #2's record revealed a Behavior Intervention Plan (BIP) dated 3/29/20. The BIP identified target behaviors in the area of aggression, self-injurious behavior and property destruction. The BIP did not identify self-stimulation or pulling his genitals out in a public area as a need.		Following the January 11-12, 2021 survey, a review of systems revealed that although policies are in place to address the need to identify and attend to consumer behavior needs as appropriate, the QP did not abide by these policies. As a result of this identified need, the QP will schedule an IPP meeting with the IDT to address the consumer's behaviors and the possibility of including the self-stimulating/pulling genitals out in public behaviors in the BSP. Additionally, the QP will work with the agency psychologist to identify redirection methods for the consumer to address the behaviors. Staff will be provided with behavior redirection training and strategies to address the consumer's behaviors. Staff will also received additional training on consumer privacy as well.	Within 60 days of approval of the plan of correction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	**5004 KENWOOD DRIVE DURHAM, NC 27712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 227	Continued From page 7 Interview on 1/12/21 with Staff E revealed that when she sees client #2 exhibiting this behavior in a public area of the home, she will redirect him to stop or redirect him to his bedroom. Interview on 1/12/21 with the Home Manager (HM) revealed that he had not seen this behavior before, and that no training had been implemented to address this behavior. The HM stated if client #2 were to exhibit this behavior, he should be redirected to his bedroom to ensure his privacy. Interview on 1/12/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed no program or training had been established for this behavior for client #2.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plans (IPP's). The	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 8 findings are: Throughout the survey on 1/11/21 and 1/12/21, all clients in the home were observed to sit in the living room, sit in their bedrooms, and sit and/or lay on the couch in the activity room. During the observations, staff were observed to sit in the living room watching television or use their personal cell phones. No clients were prompted or encouraged to actively participate in any form of active treatment. Interview on 1/12/21 with the Home Manager (HM) revealed that he completes an activity schedule each month for the clients and staff. The HM stated that staff typically follow the activity but he had just returned from an extended time off work, and the activity schedule was not completed in his absence. A. Review on 1/12/21 of client #1's record revealed an IPP dated 8/13/19. Additional review of client #1's record revealed no updated IPP since 8/13/19. Further review of client #1's record revealed no data collection for formal training objectives and programs for the period of 12/1/20 through 1/10/21. B. Review on 1/12/21 of client #2's IPP dated 4/5/20 revealed a training objective and program to use a picture/activity schedule to communicate his wants and needs every day. During observations in the home on 1/11/21 through 1/12/21, the picture/activity schedule was observed to be hanging on client #2's bedroom door. At no time during the survey was the picture/activity schedule used with client #2.	W 249	Following completion of the January 11-12, 2021 group home survey, a review of systems determined that the ICF QP was not following the policies regarding the requirements for completing the annual review and updating of consumer IPP. Due to the nature of this deficiency, we have determined it best to sever ties with the current QP. We have coordinated with the previous ICF QP (current DDA Program Director/QP) to review and update all consumer IPP, BSP, and consents. Over the next 45 days, she will work to coordinate with each guardian to schedule annual program plan meetings and update all IPP and consents. The QP will create an updated annual program schedule and provide to all consultants as well as provide guardians with annual program letters of their upcoming program meetings. In addition to the above, although policies are in place to address the requirement to provide active treatment, there is a continued need to provide additional training on active treatment as well as a review of each consumer's program plan goals, implementation of each goal, and BSP. Furthermore, staff will receive written counseling on the Autism Services, Inc. cellphone use policy. The group home lead staff will work closely with the Qualified Professional to complete the monthly activity calendar and will be required to submit the monthly plan to the Qualified Professional prior to the end of the current month. With regard to data collection, the QP found that data collection was entered incorrectly into the EHR system. Although data was entered into the system for the time period in question, there was a need to review all programs for accuracy to prevent staff confusion on data entry and retrain staff on data collection.	February 26, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 9 C. Review on 1/12/21 of client #3's record revealed an IPP dated 1/15/19. Additional review of client #3's record revealed no updated IPP since 1/15/19. Further review of client #3's record revealed no data collection for formal training objectives and programs for the period of 12/1/20 through 1/10/21. D. Review on 1/12/21 of client #4's record revealed an IPP dated 5/22/19. Additional review of client #4's record revealed no updated IPP since 5/22/19. Further review of client #4's record revealed no data collection for formal training objectives and programs for the period of 12/1/20 through 1/10/21. E. Review on 1/12/21 of client #5's record revealed an IPP dated 6/13/19. Additional review of client #5's record revealed no updated IPP since 6/13/19. Further review of client #5's record revealed no data collection for formal training objectives and programs for the period of 12/1/20 through 1/10/21. F. Review on 1/12/21 of client #6's record revealed an IPP dated 2/19/19. Additional review of client #6's record revealed no updated IPP since 2/19/19. Further review of client #6's record revealed no data collection for formal training objectives and programs for the period of 12/1/20 through 1/10/21. Interview on 1/12/21 with the Program Director confirmed that the client's should have been prompted and encouraged to participate in active treatment.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1)	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 10 Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure data relative to the accomplishment of objective criteria was documented in measurable terms. This affected 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). The findings are: A. Review on 1/12/21 of client #1's data collection on her formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review. B. Review on 1/12/21 of client #2's data collection on his formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review. C. Review on 1/12/21 of client #3's data collection on his formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review. D. Review on 1/12/21 of client #4's data collection on his formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review. E. Review on 1/12/21 of client #5's data collection on his formal programs for the period of 12/1/20 through 1/10/21 revealed no data was	W 252	A review of systems following the January 11-12, 2021 survey revealed that although staff have been completing documentation for the months in question, the documentation was entered incorrectly due the conflicting goal training programs that were entered into the system by the previous QP. As such, it was identified that there was a continued need to complete a regular review of goal documentation for accuracy, ensure the EHR system is updated regularly to reflect the current training goals, and retrain staff on EHR documentation. After reviewing through the EHR system, the QP found that the documentation was entered into the wrong areas of the EHR system for the months in question. This revealed the need to review the goals and objectives in the EHR system, update the documentation online, and provide additional training to staff on how to enter documentation into the system. With the help of our agency technical support, the QP will work to update all program data in the EHR system and provide training to staff within 45 days of approval of the plan of correction.	February 26, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 11 available for review. F. Review on 1/12/21 of client #6's data collection on his formal programs for the period of 12/1/20 through 1/10/21 revealed no data was available for review. Interview on 1/12/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she is sure staff are documenting data on training objectives and programs, and there must be a glitch in the system as to why no data is available. The QIDP confirmed that if no data is documented, it was not done.	W 252		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to update the current annual individual program plans (IPP's) for 5 of 6 audit clients (#1, #3, #4, #5 and #6). The findings are: A. Review on 1/12/21 of client #1's record revealed an IPP dated 8/13/19. Additional review of client #1's record revealed no updated IPP since 8/13/19. B. Review on 1/12/21 of client #3's record revealed an IPP dated 1/15/19. Additional review of client #3's record revealed no updated IPP since 1/15/19.	W 260	Following completion of the January 11-12, 2021 group home survey, a review of systems determined that the ICF QP was not following the policies regarding the requirements for completing the annual review and updating of consumer IPP. Due to the nature of this deficiency, we have determined it best to sever ties with the current QP. We have coordinated with the previous ICF QP (current DDA Program Director/QP) to review and update all consumer IPP, BSP, and consents. Over the next 45 days, the QP will work to coordinate with each guardian to schedule annual program plan meetings and update all IPP and consents. The QP will create an updated annual program schedule and provide to all consultants as well as provide guardians with annual program letters of their upcoming program meetings.	February 26, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 260	Continued From page 12 C. Review on 1/12/21 of client #4's record revealed an IPP dated 5/22/19. Additional review of client #4's record revealed no updated IPP since 5/22/19. D. Review on 1/12/21 of client #5's record revealed an IPP dated 6/13/19. Additional review of client #5's record revealed no updated IPP since 6/13/19. E. Review on 1/12/21 of client #6's record revealed an IPP dated 2/19/19. Additional review of client #6's record revealed no updated IPP since 2/19/19. Interview on 1/11/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she had current IPP's on a thumb drive that was located at her office and she would bring the updated IPP to the facility on 1/12/21. Additional interview on 1/12/21 with the QIDP revealed no updated IPP was available.	W 260		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior techniques which included the use of psychotropic medication for 3 of 6 audit clients (#1, #2 and #6) was reviewed and monitored by	W 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 262	Continued From page 13 the human rights committee (HRC). The findings are: A. Review on 1/11/21 of client #1's record revealed she is supported by a Behavior Intervention Plan (BIP) dated 11/30/18 to include the use of Invega, Cymbalta and Klonopin to address her behavioral needs. Review on 1/12/21 revealed no review or consent by the HRC for these behavior management medications. Interview on 1/12/21 with the Program Director revealed if no written review or consent by the HRC was available for review in client #1's record, it was not obtained. B. Review on 1/12/21 of client #2's record revealed he is supported by a BIP dated 3/29/20 to include the use of Clonazepam and Trazadone to address his behavioral needs. Review on 1/12/21 revealed no review or consent by the HRC for these behavior management medications. Interview on 1/12/21 with the Program Director revealed if no written review or consent by the HRC was available for review in client #2's record, it was not obtained. C. Review on 1/12/21 of client #6's record revealed he is supported by a BIP dated 4/1/19 to include the use of Risperdal and Ativan to address his behavioral needs. Review on 1/12/21 revealed no review or consent by the HRC for these behavior management	W 262	Following the annual survey, the systems review revealed that the ICF QP was not following policy regarding the requirement to obtain guardian consent for BSPs at least annually. As a result, the QP has requested copies of the most recent BSP for each consumer from the psychologist and will review the BSP with the guardian prior to obtaining consent. Within 45 days of approval of the Plan of Correction, the QP will create a document that details the date for each consumer's BSP renewal date to monitor monthly to ensure that BSP are received, reviewed with the guardian, signed by the guardian at least annually, and reviewed by HRC.	February 26, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 262	Continued From page 14 medications. Interview on 1/12/21 with the Program Director revealed if no written review or consent by the HRC was available for review in client #6's record, it was not obtained.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		
	This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure written informed consent was obtained for clients restrictive Behavior Intervention Plans (BIP). This affected 3 of 6 audit client's (#1, #2 and #6). The findings are: A. Review on 1/11/21 of client #1's individual program plan (IPP) dated 8/13/19 revealed client #1 is supported with a BIP. Review of client #1's record revealed a BIP dated 11/30/18 to address identified target behaviors consisting of property destruction, self-injurious behavior and hiding/stashing items. Additional review of the BIP dated 11/30/18 revealed client #1 is taking behavior management medications that includes Invega, Cymbalta and Klonopin. Further review of client #1's record revealed the last written consent signed by the guardian was obtained on 8/15/19. Interview on 1/12/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that		Following the annual survey, the systems review revealed that the ICF QP was not following policy regarding the requirement to obtain guardian consent for BSPs at least annually. As a result, the QP has requested copies of the most recent BSP for each consumer from the psychologist and will review the BSP with the guardian prior to obtaining consent. Within 45 days of approval of the Plan of Correction, the QP will create a document that details the date for each consumer's BSP renewal date to monitor monthly to ensure that BSP are received, reviewed with the guardian, signed by the guardian at least annually, and reviewed by HRC.	February 26, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 15	W 263		

written consent for client #1 has not been obtained since the last signed consent on 8/15/19.

B. Review on 1/11/21 of client #2's IPP dated 4/5/20 revealed client #2 has an objective to "display 30 or fewer target behaviors as defined in his BIP for 4 out of 12 months." Additional review of client #2's record revealed a BIP dated 3/29/20 to address identified target behaviors consisting of aggression, self-injurious behavior and property destruction and is taking medication for behavior management that includes Clonazapam and Trazadone. Further review on 1/12/21 of client #2's record revealed no written informed consent signed by the guardian.

Interview on 1/12/21 with the QIDP revealed that written informed consents for client #2's BIP and behavior management medications have been sent to the guardian but have not been received by the facility. The QIDP confirmed that client #2 has been receiving behavior management medications and has been supported by a BIP since 3/29/20 without having the guardian provide written informed consent.

C. Review on 1/12/21 of client #6's IPP dated 5/22/19 revealed that client #6 is supported by a BIP. Review on 1/12/21 of client #6's record revealed a BIP dated 4/1/19 to address identified target behaviors and behavior management medications that includes Risperdal and Ativan. Further review of client #6's record revealed the last written consent signed by the guardian was obtained on 5/2/19.

Interview on 1/12/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 16 written consent for client #6 has not been obtained since the last signed consent on 5/2/19.	W 263		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, nursing failed to provide 2 of 6 audit clients (#1 and #5) with required services to meet the client needs. The findings are: A. During observations in the home on 1/11/21 at 5:30 pm, client #1 was given assistance by staff B to pour an unmeasured amount of water into a large glass with no marks for ounces and an unmeasured amount of milk into a small glass. Client #1 drank all of the fluids after eating her meal. An additional observation on 1/12/21 at 7:00 am, client #1 had a small glass of orange juice and a large glass of water. Neither glasses had information about the capacity for fluid ounces. Client #1 drank all of the fluids after eating her meal. Review on 1/11/21 of client #1's physician's orders, signed on 7/22/20, it stated that she was on an 80 ounce fluids restriction due to stage III chronic kidney disease. An additional review on 1/12/21 of client #1's daily fluid log, indicated that staff were not always recording her fluids during the day and/or did not always calculated her daily total. There was missing data during the months: January,	W 331	Following the January 11-12, 2021 annual survey, a review of systems revealed that although systems were in place to monitor fluid intake for the consumer in the review, there was a need to increase supervision and retrain staff related to special health precautions. As a result of this review, the RN will complete an updated inservice with staff pertaining to the consumer's fluid restriction including what and why the restriction is in place, how to measure fluids, and requirements for documenting fluid intake. At least monthly, the RN will review the fluid intake forms and present the information for review during the monthly IDT meetings. Additionally, the house manager will review the fluid intake forms in the home at a minimum of weekly.	Within 60 days of approval of plan of correction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 17	W 331		

February, July, November 2020 and January 2021. There were no instructions on how to record the fluids or instructions for the restrictions at meals and medication administration.

During an interview on 1/12/21 with Staff E, she indicated that she already knew how many fluids each type of glass held, so could pour without measuring first. When asked how many fluids each glass held, staff E held each cup and stated 4 ounces for the small glass and 8 ounces for the large glass. Staff E was asked to demonstrate how much each glass held by using measured fluids to fill them. It was later determined that the small glass held 12 ounces and the large glass held 20 ounces.

During an interview with the home manager (HM) on 1/11/21, he revealed that the facility had purchased a very large measuring cup, which was located in the kitchen's cabinet, for staff to use to measure client #1's drinks. The HM indicated that staff could not assume they were pouring the correct amount of fluids and that it had to be measured. He acknowledged that unmeasured fluid amounts might not reflect accuracy on the fluids log.

An interview with the nurse on 1/12/21 regarding client #1's fluid restriction revealed she was supposed to monitor the fluids log but had not looked at it in awhile. The nurse indicated that the fluid log was supposed to contain a spreadsheet on how to measure the fluids. The nurse stated that client #1 was at risk of developing kidney failure if she had too many fluids and the staff needed to be retrained.

B. Review of client #1's physician orders on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 18 7/22/20 required monitor of laboratory results of the comprehensive metabolic panel (CMP) every 3 months and the basic metabolic panel (BMP) and lipid test every 6 months. Review of the current laboratory tests were last completed in January 2020. An interview with the nurse on 1/12/21 revealed that she was responsible for monitoring that lab work was completed, per physician's orders. The nurse reviewed her records and indicated that the last laboratory test that she had on file for client #1 was in January 2020. C. Review on 1/12/21 of client #5's pharmacy review, dated 10/5/20 it called for clarifying if client #5 should remain on Amlodipine 10 mg daily due to an allergy to calcium channel blockers. The pharmacist requested, "Please clarify this allergy and provide documentation if [client #5] can take this medication with no adverse effects." There was no response from the physician to the pharmacist. A review on 1/12/21 of client #1's medication administration records (MAR) since October 2020, indicated that he has continued to receive a daily dose of Amlodipine 10 mg. An interview on 1/12/21 with the nurse, revealed she visited the home monthly and was responsible for reviewing the quarterly pharmacy reviews and following up with the physician if necessary. The nurse acknowledged that she did not recall the pharmacist's request and must have overlooked her comments.	W 331	Following the annual survey, a systems review revealed that although policies are in place to address the requirements to ensure that consumer medical appointments are completed as required, there were areas requiring improvement surrounding the review of consumer medical appointments and documentation related to medical appointments. While there is currently a system in place for detailing dates for consumer medical appointments, there is a need for a more thorough review of consultation forms following medical appointments. As a result, the RN will review all medical appointment consultation forms on a minimum of a monthly basis for appointments within the current month. The home manager will review all consultations forms within 72 hours following the appointment and provide a copy to the RN by completion of the review. The RN will monitor the house manager to make sure that all appointments and labs have been completed as required. Following completion of the annual survey, a systems review revealed a need to increase review of quarterly pharmacy review documentation. Due to the identified need, the RN will review all pharmacy review notes immediately following the quarterly psychiatric meeting. The RN will ensure that all information and requests are followed-up on by the house manager and review the monthly consultation forms for any requests made by the pharmacist that require a medical visit.	Within 60 days of approval of plan of correction Within 60 days of approval of plan of correction
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i)	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING _____ B. WING _____	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	**5004 KENWOOD DRIVE** **DURHAM, NC 27712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 340	Continued From page 19 Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, policy review and staff interviews, the facility failed to ensure staff were sufficiently trained in adhering to their COVID-19 policy; and ensure that staff report new health conditions to the nurse. A. During observations in the home on 1/11/21 at 12:30 pm, the qualified intellectual disabilities professional (QIDP) entered the home, wearing a loose fitting surgical mask, that sometimes exposed her nostrils. The QIDP was not observed taking her body temperature or recording answers on the facility's COVID-19 screening form. The questions on the form contained the following: 1. Have you or anyone in your home been out of the country in the past 21 days? 2. Is anyone in your home currently showing symptoms of fever of 100 degrees or higher, cough, runny nose, sneezing, diarrhea, vomiting, nausea, and /or respiratory issues? 3. Have you been in contact with anyone in the last 21 days who has been diagnosed with the coronavirus or shown symptoms of the flu? 4. Will you be attending any large venue events that will bring you and/or your loved one in contact with a group of people consisting or 25 or more?	W 340	Although there are policies in place to address covid-19, the systems review following the annual survey revealed areas needing improvement surrounding staff adherence to our Covid-19 procedures. Due to the nature of this deficiency, we have determined it best to sever ties with the current QP. We have appointed our DDA Program Director/QP who previously served as the agency ICF QP to oversee the services for the ICF consumers. These deficiencies identified the need for the RN to retrain staff on the agency's covid-19 precautions (screening, how to wear masks, symptoms, etc.) Additionally, the QP will ensure that all staff are retrained on making sure that all guests, visitors, staff, contractors, and consultants are completing the covid-19 screening form as well as taking temperatures and documenting. The home manager will review covid-19 screening forms daily. The QP will review all screening forms on a monthly basis to ensure completion.	Within 60 days of approval of plan of correction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	**5004 KENWOOD DRIVE** **DURHAM, NC 27712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 340	Continued From page 20	W 340		

In addition, the QIDP was observed having random coughs as well as complaining about being hot, until the end of the observation at 6:00 pm.

The following day, 1/12/21, the QIDP arrived at the home at 9:30 am and was wearing a face mask. The QIDP was observed to not take her temperature or answer any of the screening questions. She was observed coughing, sweating and told a surveyor that she had to see a doctor today because she felt "like a truck hit her." The QIDP left the facility at 9:55 am.

Review on 1/11/21 of the facility's COVID-19 Emergency Preparedness Plan, dated 2/1/20 revealed that staff must take their temperature and if over 100.0 degrees must immediately leave premises and cannot work without clearance from a medical doctor and a negative COVID-19 test.

Review on 1/12/21 of the facility's temperature log binder required that "All Kenwood Staff Must Take Their Temperature Before Starting Their Shift." There were no screening forms for the QIDP on 1/11/21 and 1/12/21, however the other staff on duty, had completed forms.

Interview on 1/12/21 with the QIDP regarding the employee COVID-19 screening process, she insisted that she had completed the forms but did not produce copies.

B. On 1/12/21, the survey team entered the home between the hours of 6:00-7:00 am. Two staff were on third shift duty, staff D and staff E. Neither staff recorded body temperature of the two surveyors and or requested that COVID-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 340	Continued From page 21 screening forms being completed upon entering the home. Interview on 1/12/21 with staff E revealed that she had not dealt with any visitors on her shift since the pandemic, so it did not occur to her to request health screening. Interview on 1/12/21 with staff D revealed that he did not ask the survey team to be screened because he made the assumption that we were COVID-19 free since we were conducting surveys. Interview on 1/12/21 with the house manager (HM) revealed that it was the facility's policy, which was posted throughout the house, that every employee and every visitor must be screened. The HM explained that he conducted staff meetings twice a month and had repeatedly covered his expectations. Interview on 1/12/21 with the nurse revealed training on COVID-19 was offered to staff on 12/15/20. The nurse stated that everyone, including the QIDP should be screened when entering the home. The nurse explained if the screening was bypassed, it could potentially infect consumers and staff since COVID-19 was highly contagious. C. During observations in the home, over 1/11/21 and 1/12/21, client #5 was observed coughing on occasion; client #1 and #6 were observed sneezing and client #2 and #3 were observed wiping nasal drainage across the back of their hands. Review of the client #1, #2. #3, #5 and #6's	W 340	C. Although there are policies and procedures in place to address covid-19, the systems review following the annual survey revealed areas needing improvement surrounding staff adherence to our Covid-19 procedures. These deficiencies identified the need for the RN to retrain staff on the agency's covid-19 precautions (3Ws, symptoms checklist, reporting, etc). The home manager will review covid-19 symptoms checklist forms daily. The QP will review all symptoms checklist forms on a monthly basis to ensure completion. Of note, all consumers were quarantined immediately and scheduled to get a covid-19 test following the notification of symptoms.	Within 60 days of approval of plan of correction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 340	Continued From page 22 medical record had no documentation of any new health condition that related to sneezing, coughing and runny nose. Interview on 1/12/21 with staff E regarding client #5 coughing over the last two days revealed that she had not noticed any coughing. She stated that if she was aware that he was coughing, she would immediately contact the nurse. Interview on 1/12/21 with the nurse revealed that her expectation was for staff to relay any new symptom to her immediately. She further stated that staff were present at an in-service last month that discussed COVID-19 and any potential symptoms. The nurse stated that had she known that some of the clients and staff had potential COVID-19 symptoms, she would immediately put all clients on quarantine, requiring them to stay inside of their rooms. All clients and staff would have to be tested and staff wear full personal protective equipment (gowns, gloves, face masks and face shields). Interview on 1/12/21 with the program director revealed that since the pandemic, that if any client developed a cough, sneezing or runny nose, the nurse would issue a quarantine for the home.	W 340		
W 374	DRUG ADMINISTRATION CFR(s): 483.460(k)(7) The system for drug administration must assure that drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law.	W 374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 374	Continued From page 23 This STANDARD is not met as evidenced by: Based on observation, interviews and document review, the facility failed to ensure all drugs were packaged and labeled in accordance with State law. This affected 1 of 6 audit clients (#1). The finding is: During observations on 1/12/21 during medication administration, Staff D was observed to administer Artificial Tears, one drop in each eye, to client #1. The bottle of Artificial Tears was not labeled. Interview on 1/12/21 with Staff D confirmed that the bottle of Artificial Tears was not labeled with a pharmacy label to identify the client, the person prescribing the medication, and dosage information. Staff D reported that the bottle of Artificial Tears did not require a label because the bottle had manufacturer dosing instructions on the side of the bottle. Interview on 1/12/21 with the facility nurse confirmed that the bottle of Artificial Tears should have been labeled with a pharmacy label.	W 374	After completion of the annual survey, a review of systems revealed that although policies and procedures are in place to address medication administration and staff responsibilities pertaining to medication administration, there is a continued need to retrain staff on medication administration procedures. Based on this observation and within 60 days of approval of the plan of correction, the RN will retrain staff on medication procedures including identifying and reporting labeling and storage issues. The RN will also retrain the home manager on how to monitor for medication upkeep including labeling. The QP will retrain the home manager on his responsibilities related to the medication administration including completing a daily medication closet review as well as completing a medication closet checklist. Lastly, the home manager will ensure that the weekly medication closet checklist is completed each week and will submit to the QP for review monthly.	Within 60 days of approval of plan of correction
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G246	A. BUILDING ______ B. WING ______	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD DRIVE HOME	5004 KENWOOD DRIVE DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 24 Based on observations, record review and staff interviews, the facility failed to furnish eye glasses for 1 of 6 audit clients (#1) with visual impairment. The finding is: During observations in the home on 1/11/21-1/12/21, client #1 did not wear any eye glasses. An additional observation on 1/11/21 of client #1 placing cartons of yogurt next to each client's place setting, revealed that client #1 had trouble with her vision and staff C had to guide her hand to the correct location. Review on 1/11/21, an undated photograph of client #1 in her medical chart, displayed her wearing eye glasses. An additional review of client #1's individual program plan, dated 8/13/19 revealed that she had severe myopia with astigmatisms and bilateral cataracts. Interview on 1/12/21 with the home manager revealed that he had worked in the home for three years and never knew that client #1 wore glasses. He did not know the status of her prescription. Interview on 1/12/21 with the nurse revealed that she had worked at the home for three years and made monthly visits. The nurse stated that she was unaware that client #1 needed eye glasses and would need to follow up.	W 436	Based on observations and reviews from the January 11-12, 2021 annual survey, a systems review revealed that although policies are in place to address ensuring that consumer medical needs are met, it was identified that there was a continued need to provide additional supervision related to the medical needs of individual consumers. Due to these observations and with follow-up, it was identified that the consumer had previously been scheduled for cataract surgery following the completion of the annual survey. The consumer's cataract surgery was completed in January 2021 and a follow-up appointment was scheduled with her doctor. While the follow-up appointment is scheduled for a future date, the doctor indicated that they would have to reassess the consumer at the follow-up appointment to determine whether the consumer would require eye glasses. Subsequent to the follow-up appointment, the home manager is expected to immediately provide an update to the RN and QP in writing and provide a copy of the consultation form to both for review. Moving forward, the IDT will ensure that the annual plan addresses any needed addendum to consumer treatment as well as review consumer treatment progress at the monthly IDT meeting.	Within 60 days of approval of plan of correction