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 ______	R 03/26/2021

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 000	INITIAL COMMENTS A revisit was conducted on 3/26/21 for all previous deficiencies cited on 1/12/21. The following deficiencies have been corrected: W130, W159, W195, W196, W227, W260, W262, W263, W331, W374 and W436. The facility remained out of compliance in W340 and had new areas of non-compliance in W242, W382 and W383.	W 000		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observations, interview and record reviews, the facility failed to ensure the individual program plan (IPP) for 3 of 6 audit clients (#2, #5 and #6) included objective training to address observed needs relative to privacy. The findings were: A. During observations in the home on 3/26/21 at 11:05am, client #5 was observed urinating in the bathroom, with the door left open. Staff was not present with client #5 in the bathroom. Review on 3/26/21 of client #5's individual program plan (IPP) dated 2/18/21 did not identify	W 242	Although we have made efforts to correct this deficiency by providing training to staff and consumers, there continues to be a need to provide additional training as well as updating consumer Individual Program Plans. As a result, we will update consumer IPPs to reflect a privacy goal and provide additional training to staff. The Clinical Director/QP will spearhead this and provide monitoring for the next 90 days to ensure compliance with the new consumer privacy goals.	Within 30 days of approval of POC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary S. [illegible] TITLE: Clinical Director/QP (X6) DATE: 4/23/2021

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.

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W 242	Continued From page 1 a need to receive reminders to shut the door for privacy during toileting. Neither staff were on the hall while client #5 engaged in this activity. Staff would make rounds hourly to check on clients remaining in their rooms. Interview on 3/26/21 with the qualified intellectual disabilities professional (QIDP) revealed that staff have been trained to make sure clients close their doors for privacy. B. During observations in the home on 3/26/21 at 11:06 am, the door was ajar in the room of client #2. The opened door allowed anyone standing in the hall, to watch client #2 engage in self-stimulating behaviors underneath his blanket, with his right hand near his genital area. Review on 3/26/21 of client #2's IPP dated 2/15/21 revealed that he had a history of masturbating behaviors, sometimes in public. Staff should verbally redirect him and remind him that it's appropriate to do it when in private. Interview on 3/26/21 with the QIDP revealed that client #2 had privacy guidelines and signs in his room to remind him. The door to his room should be shut if he is going to engage in masturbating, even under his blanket. C. During observations in the home on 3/26/21 at 11:55am, client #6 was observed to walk into the bathroom, and sit on the toilet with the door wide open. Neither staff were on the hall, during the observation. Instead staff were in the office and kitchen areas. Review on 3/26/21 of client #6's IPP dated 2/10/21 revealed that he needed reminders to	W 242		

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W 242	Continued From page 2 close the door for privacy when using the bathroom. Interview on 3/26/21 with the qualified intellectual disabilities professional (QIDP) revealed that staff have been trained to make sure clients close their doors for privacy.	W 242		
{W 340}	NURSING SERVICES CFR(s): 483.460(c)(5)(i) 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, record reviews and staff interviews, the facility failed to ensure that staff were competently trained in recording fluids for 1 of audit clients (#1) on fluid restrictions and adhering to their COVID-19 policy. The findings were: A. During observation in the home on 3/26/21 at 7:25am, client #1 was directed by Staff B to fill her cup with an unmeasured amount of water using the faucet at the kitchen sink. Staff B was unaware that client #1 had already drunk all of the water before she gave her pills during medication administration. Staff B directed client #1 to go to the kitchen and get more water to swallow her pills. Staff B did not accompany client #1 to the kitchen to determine how much water she consumed.	{W 340}	While revisions and training were provided to address this standard and to ensure compliance, a review of systems in our most recent resurvey revealed a need to provide additional training and oversight of nursing services to include consumer fluid intake. As a result, our RN will provide additional training to staff on properly measuring and documenting consumer fluid intake. Following implementation, the RN will provide biweekly monitoring until staff demonstrate a thorough understanding of how to properly document fluid intake. Additionally, staff will be retrained on covid-19 protocols including mask wearing and screening. The staff will be trained on the importance of mask wearing and the requirements by the agency and the State of North Carolina as well as requirements to immediately screen every individual who enters the home. Regular unannounced visits will be conducted by the RN and Clinical Director to assess staff compliance with covid-19 protocols. After discussing this citation with the Executive Director, the administrative team is in agreement that staff who do not follow this requirement will receive a written warning as all staff are aware and trained on agency covid-19 policies.	Within 30 days of approval of POC

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{W 340}	Continued From page 3 An additional observation in the home on 3/26/21 at noon, Staff B gave client #1 a small cup and told her to get water for lunch. Client #1 filled her cup independently from the refrigerator's water dispenser. The contents of the cup was not checked afterwards. Review on 3/26/21 of client #1's physician orders signed on 1/6/21 read fluid restriction on 80 oz daily maximum. Review on 3/23/22 revealed the Feb 2021 Fluid Intake Log, read a note from the nurse: "Attention all staff. Please review and sign indicating your understanding. Call with questions. Complete ASAP." An audit of random dates were pulled from Fluid Intake Log in March, 2021. On 3/7/21 staff recorded that client #1 received the following ounces: 16,6,6,8,8,12,6,8,10,6,4=79 when the correct amount was 90 oz. On 3/22/21 staff recorded that client #1 received the following ounces: 16,6,6,8,8,12,6,8,12,4=80 ounces when the correct amount was 86 oz. An interview on 3/26/21 was conducted with the nurse who indicated that when she retrained staff last month, she reiterated the purpose of the fluid log and how to measure the fluid. Special cups were purchased for measuring fluids for client #1. The nurse indicated that client #1 could fill her own up as long as the fluid had been measured first. B. During morning observations in the home on 3/26/21 at 7:20am, client #4 opened the surveyor. Staff A was sitting at the kitchen table and did not have on a face mask. The surveyor then proceeded to observe medication administration	{W 340}		

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{W 340}	Continued From page 4 of clients #1 and #2 with Staff B. Staff did not ask the surveyor to complete any screening questions or take body temperature until 7:45am when Staff B brought it up. Interview with Staff A on 3/26/21 revealed that she did not have on her face mask because she had just finished cooking breakfast. She acknowledged that she was aware it was supposed to be worn at all times. Staff A further stated that she did not ask the surveyor to self-screen upon entry because she thought maybe a new staff was arriving to work. Interview with Staff B on 3/26/21 revealed that she did not know that the surveyor had not been screened. Staff B revealed that anyone entering the home must screen for COVID-19 and showed the surveyor where the information was located. Interview with the nurse on 3/26/21 revealed that staff have been trained on the COVID-19 policy and are expected to immediately screen everyone who comes to the home. Their temperature must be checked as well as COVID-19 questions asked. She further stated that all staff must wear a face mask that covers their nose and mouth at all times in the home.	{W 340}		
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 observations and staff interviews, the	W 382		

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W 382	Continued From page 5 facility failed to ensure that all medications remained locked when not in use. The findings are: During observations in the home on 3/26/21 at 11:35am, the home manager (HM) removed physician orders from the medication closet for the surveyor to review. There were no locked cabinets in the closet. The medications were in individual plastic bins, left on a shelf. The HM left the closet door opened, with the keys in the back of the door handle. The HM then left the room and went across the hall to her office, leaving the surveyor alone with the medications. The HM returned to the room at 11:52am and closed the door to the closet and locked it, after the physician orders were returned. An additional observation on 3/26/21 at 11:58am, the HM had opened the medication closet so that Staff B could help her look at a bottle of medication. The bottle of medication was handed to the surveyor to read the label. The HM then closed and locked the medication closet door, but left the bottle of eye drops with the surveyor, when she walked out the room for a minute. Interview with the HM on 3/26/21 revealed that she was unaware of her actions and commented, "I have got to do better." Interview with the qualified intellectual disabilities professional (QIDP) on 3/26/21 revealed that the medication closet should be locked when not in use. Staff have been taught in med training how to secure the medications. The QIDP acknowledged that the HM who was new, had previous experience as a medication technician.	W 382	A review of systems revealed a need to provide additional training to staff on proper protocol when administering or handling medications. While our home manager is new to the management position, the identified need to provide additional training in the area of drug storage and monitoring will be addressed by providing additional training and oversight to staff. All staff will be retrained on medication administration protocol including ensuring that the medication closet will remain locked when not in use or able to be supervised by an ASI staff.	Within 30 days of approval of POC

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W 383	Continued From page 6	W 383		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure that only authorized persons have access to keys to the medication closet. The finding is: During observations in the home on 3/26/21 at 11:35am, the home manager (HM) removed physician orders from the medication closet for the surveyor to review. The HM left the closet door opened, with the keys in the back of the door handle. The HM then left the room and went across the hall to her office, leaving the keys in the door until 11:52am, with the surveyor alone in the room. Interview with the HM on 3/26/21 revealed that she was unaware of her actions and commented, "I have got to do better." Interview with the qualified intellectual disabilities professional (QIDP) on 3/26/21 revealed that the medication key should be kept in a lock box or on someone's person at all times, when not in use.	W 383	A review of systems revealed a need to provide additional training to staff on proper protocol when administering or handling medications. While our home manager is new to the management position, the identified need to provide additional training in the area of drug storage and monitoring will be addressed by providing additional training and oversight to staff. All staff will be retrained on medication administration protocol including ensuring that the medication closet will remain locked when not in use or able to be supervised by an ASI staff.	Within 30 days of approval of POC