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 _____	03/08/2023

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 254	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that contribute to an overall understanding of the client's ongoing level and quality of functioning. This STANDARD is not met as evidenced by: Based on record review and interview the qualified intellectual disabilities professional (QIDP) failed to review the written training programs for 3 of 3 audit clients (#1, #2 and #3). The findings are: A. Review on 3/7/23 of client #1's individual program plan (IPP) dated 6/2/22 revealed he had several formal written objectives which included: sorting items "in or out" when making decisions about storing items in his bedroom, washing his body with no more than 2 verbal prompts (VP) 75% time, drying his body with 2 VP 75% of the time, brushing his teeth for 2 minutes with a timer, engaging in 30 minutes of physical exercise and completing a purchase 50% time for 12 consecutive months. Review on 3/8/23 of client #1's progress summaries for the above formal objectives provided by the qualified intellectual disabilities professional (QIDP) revealed only raw data recorded electronically by direct care staff for the months of December 2022, January 2023 and February 2023. Interview on 3/8/23 with the QIDP confirmed she had not reviewed client #1's written formal objectives since she started in February 2023 and that she could not locate any progress summaries in 2022 for client #1. B. Review on 3/7/23 of client #2's IPP dated	W 254		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 _____	03/08/2023

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 254	Continued From page 1 1/24/23 revealed she has the following written formal objectives: a behavior support program (BSP) to reduce target behaviors to 15 or less per month for 9/10 months, a program to make her bed with gestural cues 85% time, put dirty clothing in the hamper, dust her room with no more than 1 gestural prompt with 85% time and vacuum room with no more than a gestural prompt 85% time. Interview on 3/8/23 with the QIDP revealed she only had the electronic raw data recorded by direct care staff from 2022-March 7, 2023 for client #2's written formal objectives. Further interview confirmed she had not reviewed client #2's written formal objectives since she started in February 2023 and that she could not locate any progress summaries in 2022 for client #2. C. Review on 3/7/23 of client #3's IPP dated 2/9/2023 revealed he has the following written formal objectives: Will complete oral hygiene tasks with no more than 3 VP for 25% time, will use earned bucks to purchase items from the household store with no more than 3 VP with 25% accuracy and will mop the floor with no more than 2 VP with 65% accuracy. Interview on 3/8/23 with the QIDP revealed she only had the electronic raw data recorded by direct care staff from 2022-March 7, 2023 for client #3's written formal objectives. Further interview confirmed she had not reviewed client #3's written formal objectives since she started in February 2023 and that she could not locate any progress summaries in 2022 for client #3.	W 254		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)	W 263		

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 _____	03/08/2023

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 2 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. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a written informed consent was obtained for the restrictive Behavior Support Plans (BSP) for 2 of 3 audit clients (#1 and #2). The findings are: A. Review on 3/7/23 of client #1's BSP dated 1/3/2023 for target behaviors of verbalizing obsessive thoughts of death which incorporates the use of Elavil 25mg. (1) at 7:00am daily revealed there was no legal written informed consent for this program. Interview on 3/8/23 with the qualified intellectual disabilities professional (QIDP) and the Program Director revealed the team is working to establish guardianship for client #1. Further interview confirmed that client #1 was admitted on 1/19/22. Additional interview confirmed the team has established client #1 is not able to make informed decisions about medical decisions or his placement so they are working to establish guardianship for him. The Program Director and QIDP also confirmed as client #1 is his own guardian, this program which included risks versus the benefits of the medication had not been explained to him. B. Review on 3/7/23 of client #2's BSP dated 1/9/22 for the target behaviors of property destruction, self-injurious behaviors, hiding and stashing items revealed this BSP incorporates the use of Invega, Keppra and Clonidine. Review of	W 263		

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 _____	03/08/2023

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 3 client #2's individual program plan (IPP) dated 1/24/23 revealed she has been adjudicated and a local department of social services (DSS) serves as her legal guardian of the person (GOP). Review of the written informed consent for this program is dated 2/18/22 and indicated the consent expired in 1 year from the date which it was signed. Further review revealed no updated current written consent from the guardian for client #2's BSP. Interview on 3/8/23 with the QIDP and the Program Director revealed they could not locate current informed consent for client #2's restrictive BSP dated 1/9/22.	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 observations, record review and interviews, the facility failed to ensure 1 of 3 audit clients (#1) were provided nursing services in accordance with their medical needs. The findings are: A. Review on 3/7/23 of client #1's individual program plan (IPP) dated 6/2/22 revealed he was admitted the the facility on 1/19/22. Further review revealed he had diagnoses Intellectual Disabilities, Autism, Migraines, Hypertension, Hyperlipidemia and Benign Prostatic Hypertrophy. Review on 3/8/23 of client #1's physician orders dated 1/23/23 revealed client #1 is prescribed Amlodipine 10 mg. (1) tablet daily and Hydrochlorothiazide (HCTZ) 12.5 mg. (2) tablets	W 331		

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 _____	03/08/2023

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 4	W 331		

daily for Hypertension, Plavix 75 mg. (1) tablet daily and Aspirin 81 mg. (1) daily to prevent blood clots, Potassium Chloride 20 meq daily for his cardiac status and Simvastin 10 mg. for elevated cholesterol.

Review on 3/8/23 of client #1's blood pressure readings that are prescribed to be taken and documented on Sundays revealed the following for February 2023-March 2023:

2/5/23: 166/84
2/12/23: 172/80
2/19/23: 172/80
2/29/23: 186/84
3/5/23: 140/72

Interview on 3/8/23 with the Residential Manager (RM) revealed staff had not reported these blood pressure readings to the facility nurse and that the nurse had not trained staff to identify blood pressure parameters for which she wanted to be notified. Additional interview revealed direct care staff had not been trained on the purpose of client #1's medications or on recognizing signs and symptoms of high blood pressure and appropriate interventions.

Interview on 3/8/23 with the facility nurse revealed she had not reviewed the medication administration records to review client #1's recent blood pressure readings nor had she trained direct care staff on recognizing signs and symptoms of high blood pressure and appropriate interventions. Additional interview revealed she had not reviewed with direct care staff on what parameters for client #1's blood pressure readings she was to be notified.

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 _____	03/08/2023

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 5	W 331		

Interview on 8/8/23 with the qualified intellectual disabilities professional (QIDP) and the Program Director revealed nursing was responsible for training staff in recognizing signs and symptoms of illness, establishing appropriate medical interventions and alerting staff what medical issues for which she was to be immediately notified.

B. Interview on 8/8/23 with the RM revealed that she has attempted to contact nursing on several occasions regarding clients feeling unwell, elevated blood pressure readings and has been unable to reach the facility nurse at all and on some occasions until several hours later.

Interview on 3/8/23 with the facility nurse revealed she was unaware of any unsuccessful attempts by staff to reach her and that she tries to return calls from facility staff at her earliest convenience.

Review on 3/8/23 revealed there was no documentation available from the facility nurse regarding a log of phone calls from facility staff nor was there a log at the facility from staff regarding attempted contacts to Nursing.

Interview on 3/8/23 with the Program Director revealed in a recent staff meeting last week that concerns were brought up from staff about unsuccessful attempts to reach the facility nurse however further interview confirmed that no plan of action was developed to address this issue.

C. During observations on 3/7/23 at 4:30pm, client #1 told staff B and the RM he had a headache when staff tried to get him to come to the activity room to join clients #2 and #5 for a tabletop activity.

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 _____	03/08/2023

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 6 Immediate interview on 3/7/23 with staff B and the RM revealed client #1 is diagnosed with frequent migraines and has prescribed medications that he takes daily for them. In addition, the RM stated he has a standing order for additional Tylenol 650 mg. that he can take for fever or discomfort. During continued observations on 3/7/23 the RM put some ice in a zip lock bag and told client #1 to put it on his head. When asked if this is an intervention nursing had recommended, the RM stated, "No, but I am trying to make him more comfortable." When asked of the RM was to contact nursing about client #1's headache or any medication to be given, she stated, "No." When asked how often client #1 experiences headaches, she stated, "Daily." Interview on 3/7/23 with staff A revealed client #1 complains about daily headaches. Review on 3/8/23 of client #1's physician orders dated 1/23/23 revealed he is prescribed Amitriptyline 25mg. daily, Magnesium Oxide 250 mg. daily and APAP 500mg. Tylenol caplets daily for Migraines. Review on 3/8/23 of client #1's physician consult dated 4/28/22 revealed client #1 is prescribed Amitriptyline 25mg. daily, Magnesium Oxide 250 mg. daily and APAP 500mg. Tylenol caplets daily for Migraines. Further review revealed client #1 had previously been seen by a local neurology practice and that if this medication was not effective he should be referred back to Neurology.	W 331		

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 _____	03/08/2023

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 7 Interview on 3/8/23 with the facility nurse revealed she was aware that client #1 had been diagnosed with Migraines but that direct care staff had not reported daily incidences of headaches. Additional interview confirmed nursing had not done any training with direct care staff about when to report client #1's headaches or appropriate interventions for his headaches. The facility nurse also confirmed client #1 had not been referred back to Neurology for follow up.	W 331		
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 and interviews, nursing services failed to assure staff were adequately trained in appropriate procedures for following mask guidance in conjunction with preventing the spread of COVID-19 for 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: During observations in the facility on 3/7/23-3/8/23 from 9:00am-1pm and from 4:00pm-6:00pm staff A, staff B and the Residential Manager (RM) were not observed to wear facial masks in the facility while assisting client #5 with meal preparation and carrying out leisure activities and supper with clients #1, #2, #3, #4, #5 and #6. During this afternoon observation, there were signs in the facility in the living and dining areas that indicated direct care staff were to wear facial masks in the facility	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 _____	03/08/2023

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 8	W 340		

when working with clients.

During observations in the facility on 3/8/23 from 6:00am-8:30am, direct care staff B and staff C were not observed to wear facial masks in the facility assisting clients #1, #2, #3, #4, #5 and #6 getting up, getting dressed, packing lunches, medication administration and the breakfast meal until 4 of the clients (#3, #4, #5 and #6) departed for their vocational workshop around 8:30am. Staff C also was not wearing a facial mask when she stayed at the facility with clients #1 and #2 who stayed at the facility after 8:30am when the surveyor left the home.

Review on 3/8/23 of the facility's COVID-19 policy (undated) under section 6.2.10 revealed, " All staff will be required to receive the COVID-19 vaccine, unless exempted under CMS (Centers for Medicaid and Medicare) recognized religious or medical exemptions. The requirement applies to all direct support professionals." Additional review of this policy does not include requirements for the use of personal protective equipment (PPE) in the facility when working with clients.

Interview on 3/8/23 with the RM confirmed that her understanding was, since the corporation had mandated that all staff be vaccinated against COVID-19, that it was optional for staff to wear facial masks in the facility.

Interview on 3/8/23 with the Program Director revealed she was not aware of the current CMS facial mask mandate in ICF/IID facilities under the current Centers for Disease Control (CDC) recommendations dated 9/23/22 which require staff to wear facial masks and other personal

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 _____	03/08/2023

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 9 protective equipment as needed in healthcare facilities. Further interview confirmed nursing services had not completed recent training with direct care staff in reference to COVID-19 protections, which includes the use of facial masks to protect clients and staff in the facility.	W 340		