		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY PLETED
		34G246	B. WING_			03/	12/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KENWO	DD DRIVE HOME				004 KENWOOD DRIVE DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 030	CFR(s): 483.475(c) §403.748(c)(1), §47 §441.184(c)(1), §48 §483.73(c)(1), §483 §485.68(c)(1), §485 §485.727(c)(1), §484 §491.12(c)(1), §494 [(c) The [facility mu emergency prepare that complies with F and must be review 2 years [annually for communication plan following:] (1) Names and com following: (i) Staff.	(1) 16.54(c)(1), §418.113(c)(1), 60.84(c)(1), §482.15(c)(1), 8.475(c)(1), §484.102(c)(1), 5.542(c)(1), §485.625(c)(1), 35.920(c)(1), §486.360(c)(1), 4.62(c)(1). st develop and maintain an edness communication plan Federal, State and local laws ved and updated at least every or LTC facilities]. The n must include all of the tact information for the g services under arrangement. ians	E 03	30	DEFICIENCY)		
	§485.625(c)] The c include all of the fol (1) Names and con following: (i) Staff.	tact information for the g services under arrangement. ians					
	following:	03.748(c):] The n must include all of the			TITLE		

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 03/13/2024

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.

TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) D/	D. 0938-039 ATE SURVEY OMPLETED
		34G246	B. WING	-			3/12/2024
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		5/12/2024
KENWO	OD DRIVE HOME				004 KENWOOD DRIVE JURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	 (1) Names and confollowing: (i) Staff. (ii) Entities providin (iii) Next of kin, gua (iv) Other RNHCIs. (v) Volunteers. 	stact information for the g services under arrangement. ardian, or custodian.	EO	30			
	(1) Names and con following: (i) Staff.	tact information for the grant of the grant					
	 *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. 						
	plan must include a (1) Names and con following: (i) Staff.	tact information for the generation generation for the generation of the generation of the second seco					
	*[For OPOs at §486 plan must include a	6.360(c):] The communication all of the following:					

Facility ID: 922084

If continuation sheet Page 2 of 24

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED	
		34G246	B. WING		03	/12/2024	
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
KENWO	OD DRIVE HOME		5 D				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
E 030	 (2) Names and confollowing: (i) Staff. (ii) Entities providir (iii) Volunteers. (iv) Other OPOs. (v) Transplant and Donation Service A This STANDARD Based on interview Emergency Preparation for any contact information Review on 3/11/24 reviewed 10/27/23 information for any Interview on 3/12/2 confirmed names a standard sector and the sector and t	ntact information for the ng services under arrangement. donor hospitals in the OPO's	E 030				
E 037	§441.184(d)(1), §4 §483.73(d)(1), §48 §485.68(d)(1), §44 §485.727(d)(1), §44 §491.12(d)(1). *[For RNCHIs at § Hospitals at §482.1	10.54(d)(1), §418.113(d)(1), 60.84(d)(1), §482.15(d)(1), 3.475(d)(1), §484.102(d)(1), 35.542(d)(1), §485.625(d)(1), 85.920(d)(1), §486.360(d)(1), 403.748, ASCs at §416.54, 15, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" POs at §486.360,	E 037				

If continuation sheet Page 3 of 24

		AND HUMAN SERVICES					FORM	03/13/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		34G246	B. WING	i			03/ [,]	12/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP	CODE		
KENWO	OD DRIVE HOME				5004 KENWOOD DRIVE DURHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE
E 037	the following: (i) Initial training in e policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) Provide emerger least every 2 years. (iii) Maintain docum preparedness trainin (iv) Demonstrate st procedures. (v) If the emergency procedures are sign must conduct training procedures. *[For Hospices at § hospice must do all (i) Initial training in e policies and proced hospice employees services under arra expected roles. (ii) Demonstrate sta procedures. (iii) Demonstrate sta procedures. (iii) Provide emerger least every 2 years. (iv) Periodically revi emergency prepare employees (includir special emphasis p procedures necess others. (v) Maintain docum preparedness trainin (vi) If the emergency	emergency preparedness lures to all new and existing oviding services under volunteers, consistent with their ncy preparedness training at entation of all emergency ing. aff knowledge of emergency y preparedness policies and hificantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The of the following: emergency preparedness lures to all new and existing and individuals providing ingement, consistent with their aff knowledge of emergency ency preparedness training at iew and rehearse its edness plan with hospice ng nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency	E	037				

If continuation sheet Page 4 of 24

				O		APPROVED 0938-0391
OVIDER/SUPPLIER/CLIA INTIFICATION NUMBER:	ì í				(X3) DATE	E SURVEY PLETED
34G246	B. WING	i			03/	12/2024
OF DEFICIENCIES E PRECEDED BY FULL FIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
ſ	EC	337	,			
he updated policies and						
d):] (1) Training do all of the following: ency preparedness o all new and existing services under ers, consistent with their vide emergency ry 2 years. wledge of emergency on of all emergency on of all emergency aredness policies and ly updated, the PRTF he updated policies and] (1) The PACE the following: ency preparedness o all new and existing on-site services under participants, and their expected roles. eparedness training at wledge of emergency rming participants of nd whom to contact in on of all training. aredness policies and ly updated, the PACE						
	ANTIFICATION NUMBER: 34G246 OF DEFICIENCIES E PRECEDED BY FULL TIFYING INFORMATION) A the updated policies and d):] (1) Training do all of the following: ency preparedness o all new and existing services under ers, consistent with their vide emergency ry 2 years. wledge of emergency on of all emergency aredness policies and by updated, the PRTF he updated policies and by updated, the PRTF he updated policies and consistes envices under and existing on-site services under participants, and a their expected roles. paredness training at wledge of emergency rming participants of nd whom to contact in on of all training. aredness policies and	OVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:(X2) MUL A. BUILD34G246B. WINGOF DEFICIENCIES IE PRECEDED BY FULL TIFYING INFORMATION)ID PREF TAGhe updated policies and d):] (1) Training do all of the following: ency preparedness o all new and existing services under ers, consistent with theirvide emergency ry 2 years. wledge of emergency on of all emergency on of all emergency inducted, the PRTF he updated policies and ly updated, the PRTF he updated policies and ly updated policies and ly updated policies and ly updated policies and u their expected roles. eparedness training at wledge of emergency rming participants of nd whom to contact in on of all training. aredness policies and ly updated, the PACE	OVIDER/SUPPLIER/CLIA (X2) MULTIP A. BUILDING A. BUILDING 34G246 B. WING	OVIDER/SUPPLIER/CLIA INTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 34G246 B. WING STREET ADDRESS, CITY 5004 KENWOOD DRIV DURHAM, NC 27711 OF DEFICIENCIES E PRECEDED BY FULL TIFYING INFORMATION) ID PREFIX CROSS-REFERE he updated policies and d):] (1) Training do all of the following: ency preparedness o all new and existing services under ers, consistent with their vide emergency ry 2 years. wiedge of emergency on of all emergency on of all emergency on site services under participants, and o their expected roles. paredness policies and ly updated, the PRTF he updated policies and participants, and o their expected roles. paredness training at I (1) The PACE in the following: mory preparedness o all new and existing on-site services under participants, and o their expected roles. paredness policies and ly updated, the PACE	OVIDER/SUPPLIER/CLA NTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 34G246 B. WING 34G246 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5004 KENWOOD DRIVE DURHAM, NC 27712 OF DEFICIENCIES E PRECEDED BY FULL TRAG D. PROVIDER'S PLAN OF CORRECTIVE CROS-REFERENCED TO THE APPROPRI- DEFICIENCY) DIE PRECEDED BY FULL TRAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY) DI:] (1) Training do all of the following: ency preparedness rail new and existing services under ers, consistent with their vide emergency try 2 years. weldge of emergency on of all emergency tredness policies and y updated, the PRTF he updated policies and participants, and otheir expected roles. sparedness training at weldge of emergency ming participants of nd whom to contact in on of all training, aredness policies and y updated, the PACE	OVIDERSUPPLIER/CLA NTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATL COM 34G246 B. WING 03// 34G246 B. WING 03// OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) he updated policies and d):] (1) Training do all of the following: ency preparedness and Inew and existing services under ers, consistent with their vide emergency ry 2 years. wiedge of emergency and puperatedness and line wand existing on-site services under participants, and the updated policies and ly updated, the PRTF he updated policies and ly updated policies and ly updated, the PRTF he updated policies and ly updated policies and ly updated, the PRTF he updated policies and ly updated, the PACE 1 (1) The PACE the following: ency preparedness rail new and existing on-site services under participants, and the inexpected roles, sparedness training at wiedge of emergency ming participants of nd whom to contact in on of all training. aredness policies and y updated, the PACE

If continuation sheet Page 5 of 24

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 03/13/2024 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		34G246	B. WING			03	8/12/2024
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KENWOO	DD DRIVE HOME				5004 KENWOOD DRIVE DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 037	Program. The LTC following: (i) Initial training in e policies and proced staff, individuals pro arrangement, and v expected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness traini (iv) Demonstrate sta procedures. *[For CORFs at §48 CORF must do all c (i) Provide initial tra preparedness polici and existing staff, ir	at §483.73(d):] (1) Training facility must do all of the emergency preparedness ures to all new and existing oviding services under rolunteers, consistent with their ncy preparedness training at entation of all emergency ng. aff knowledge of emergency 85.68(d):](1) Training. The of the following:	E	037	,		
	 with their expected (ii) Provide emerger least every 2 years. (iii) Maintain docum (iv) Demonstrate stress procedures. All new and assigned speci the CORF's emerger their first workday. include instruction in alarm systems and equipment. (v) If the emerger procedures are sign 	roles. ncy preparedness training at					

If continuation sheet Page 6 of 24

		AND HUMAN SERVICES					FORMA	03/13/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		34G246	B. WING	i			03/1	12/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
KENWOO	OD DRIVE HOME			-	5004 KENWOOD DRIVE DURHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD E		(X5) COMPLETION DATE
E 037	Continued From pa procedures.	ge 6	E	037				
	The CAH must do a (i) Initial training in e policies and proced reporting and exting and where necessa personnel, and gue cooperation with fire authorities, to all ne individuals providing and volunteers, cor roles. (ii) Provide emergen least every 2 years. (iii) Maintain docum (iv) Demonstrate st procedures. (v) If the emergen procedures are sign must conduct trainin procedures. *[For CMHCs at §4 CMHC must provid preparedness polic and existing staff, in under arrangement with their expected documentation of th demonstrate staff k procedures. There emergency prepare years. This STANDARD is Based on record re facility failed to ensu	emergency preparedness lures, including prompt guishing of fires, protection, ary, evacuation of patients, ests, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, nsistent with their expected ncy preparedness training at						

If continuation sheet Page 7 of 24

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/13/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G246	B. WING _		03/	12/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KENWOO	DD DRIVE HOME			5004 KENWOOD DRIVE DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 037	Continued From pa The finding is:	ge 7	E 03	37		
	updated 10/27/23) of	of the facility's EP plan (last did not indicate all new and/or eceived training and/or P plan.				
E 039	confirmed training completed for all sta		E 03	39		
	§460.84(d)(2), §482 §483.475(d)(2), §48 §485.542(d)(2), §48	3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 34.102(d)(2), §485.68(d)(2), 35.625(d)(2), §485.727(d)(2), 91.12(d)(2), §494.62(d)(2).				
	at §485.542, OPO, §485.727, CMHCs	.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]:				
		cility] must conduct exercises cy plan annually. The [facility] bllowing:				
	community-based e (A) When a commu- accessible, conduct exercise every 2 ye (B) If the [facilit natural or man-mac activation of the em exempt from engag	unity-based exercise is not t a facility-based functional				

Facility ID: 922084

If continuation sheet Page 8 of 24

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G246 B. WING 03/12/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5004 KENWOOD DRIVE KENWOOD DRIVE HOME DURHAM, NC 27712** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 039 Continued From page 8 E 039 functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise: or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 922084

If continuation sheet Page 9 of 24

PRINTED: 03/13/2024

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/13/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		34G246	B. WING			03/	12/2024
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KENWO	DD DRIVE HOME				004 KENWOOD DRIVE DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	 opposite the year the exercise under paralis conducted, that in to the following: (A) A second full-second f	ency event. litional exercise every 2 years, litional exercise or functional agraph (d)(2)(i) of this section hay include, but is not limited cale exercise that is or a facility based functional r drill; or cise or workshop that is led by udes a group discussion using v-relevant emergency of problem statements, or prepared questions ge an emergency plan. lices that provide inpatient tospice must conduct e emergency plan twice per must do the following: annual full-scale exercise that d; or mity-based exercise is not t an annual individual onal exercise; or kperiences a natural or ncy that requires activation of a, the hospice is exempt from required full-scale community sed functional exercise that not limited to the following: cale exercise that is or a facility based functional	E	039			

If continuation sheet Page 10 of 24

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/13/2024 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G246	B. WING			03/	12/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KENWO	DD DRIVE HOME			-	004 KENWOOD DRIVE DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	facilitator that includ narrated, clinically-r and a set of probler messages, or prepa challenge an emerg (iii) Analyze the hos maintain documenta exercises, and emer hospice's emergend *[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF conduct exercises t twice per year. The do the following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the [PRTF, Ho actual natural or mar requires activation of [facility] is exempt for required full-scale of facility-based function (ii) Conduct an and that may includ following: (A) A second full-sc community-based of functional exercise; (B) A mock	cise or workshop led by a des a group discussion using a elevant emergency scenario, n statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop regency events and revise the cy plan, as needed. 1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must o test the emergency plan e [PRTF, Hospital, CAH] must annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or e, but is not limited to the cale exercise that is or individual, a facility-based	E	039			

If continuation sheet Page 11 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DAT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM	0938-0391 E SURVEY IPLETED 12/2024
34G246 B. WING 03/	12/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
KENWOOD DRIVE HOME 5004 KENWOOD DRIVE DURHAM, NC 27712	
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039 Continued From page 11 E 039 led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency events and revise the [facility's] emergency events and revise the [facility's] emergency and as needed. "[For PACE at \$460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (1) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (i) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, afacility based functional exercise; or (B) A mock disaster dril; or (C) A tabletop exercise or workshop that is led by	

Facility ID: 922084

If continuation sheet Page 12 of 24

		AND HUMAN SERVICES				FORM	03/13/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G246	B. WING	i		03/	12/2024
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KENWOO	OD DRIVE HOME				5004 KENWOOD DRIVE DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	a facilitator and inclusing a narrated, clisscenario, and a set directed messages, designed to challen (iii) Analyze the PA maintain documenta exercises, and emerpency and the emergency and the emergency set the emergency including unannoun emergency procedul ICF/IID] must do the (i) Participate in an is community-based function (B) If the [LTC facility test and the emergency for the facility is exemined in the emergency for the facility based function (B) If the [LTC facility is exemined individual, facility-based function (C) A second full-scale individual, facility-based functional exercise; (B) A mock disaster (C) A tabletop exert a facilitator includes narrated, clinically-rest and the facility includes the emergency for the functional exercise individual facility for the functional exercise individual exercis	udes a group discussion, inically-relevant emergency of problem statements, , or prepared questions ge an emergency plan. .CE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed. at §483.73(d):]] must conduct exercises to plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise. ty] facility experiences an an-made emergency that of the emergency plan, the pt from engaging its next e community-based or ased functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or an individual, facility based or	E	039	3		

		AND HUMAN SERVICES				FORM	03/13/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
1		34G246	B. WING			03/*	12/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KENWO	OD DRIVE HOME				004 KENWOOD DRIVE DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	messages, or prepa challenge an emerg (iii) Analyze the [LT and maintain docum exercises, and emerg [LTC facility] facility" *[For ICF/IIDs at §4 (2) Testing. The ICF to test the emergen The ICF/IID must dd (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functii (B) If the ICF/IID ex man-made emerge the emergency plan engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and incl using a narrated, cl scenario, and a set directed messages designed to challen (iii) Analyze the ICF	ared questions designed to gency plan. C facility] facility's response to nentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed. 83.475(d)]: F/IID must conduct exercises icy plan at least twice per year. o the following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or. speriences an actual natural or ncy that requires activation of h, the ICF/IID is exempt from the individual, facility-based following the onset of the itional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based or	EC	139			

Facility ID: 922084

If continuation sheet Page 14 of 24

		AND HUMAN SERVICES				FORM	03/13/2024 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		34G246	B. WING			03/1	2/2024		
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
KENWOO	OD DRIVE HOME		5004 KENWOOD DRIVE DURHAM, NC 27712						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
E 039	ICF/IID's emergence *[For HHAs at §484 (d)(2) Testing. The to test the emergen least annually. The (i) Participate in a fu	y plan, as needed. .102] HHA must conduct exercises icy plan at HHA must do the following: ull-scale exercise that is	EC)39					
	community-based; (A) When a cor accessible, conduct facility-based function or. (B) If the HHA or man-made emer of the emergency p engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi opposite the year the exercise under para is conducted, that limited to the follow (A) A second functional exercise; (B) A mock disa (C) A tabletop et led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the HH.	or mmunity-based exercise is not t an annual individual, onal exercise every 2 years; experiences an actual natural gency that requires activation lan, the HHA is exempt from a required full-scale or individual, facility based following the onset of the itional exercise every 2 years, he full-scale or functional agraph (d)(2)(i) of this section it may include, but is not ing: ill-scale exercise that is or an individual, facility-based or							

If continuation sheet Page 15 of 24

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/13/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED	
		34G246	B. WING			03/ [,]	12/2024
NAME OF F	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
KENWO	DD DRIVE HOME				5004 KENWOOD DRIVE DURHAM, NC 27712		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	emergency plan, as *[For OPOs at §486 (d)(2) Testing. The to test the emergen following: (i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenarie statements, directe questions designed plan. If the OPO ex- man-made emergenthe emergency plan engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followin (i) Conduct a paper least annually. A tal discussion led by a clinically-relevant en- of problem stateme prepared questions emergency plan. (ii) Analyze the RNH maintain document and emergency events emergency plan, as	a needed. 3.360] OPO must conduct exercises icy plan. The OPO must do the -based, tabletop exercise or nnually. A tabletop exercise is nd includes a group narrated, clinically relevant o, and a set of problem d messages, or prepared to challenge an emergency periences an actual natural or ncy that requires activation of h, the OPO is exempt from required testing exercise of the emergency event. D's response to and maintain II tabletop exercises, and and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct e emergency plan. The RNHCI ng: -based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set onts, directed messages, or designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's	EC	039			

Facility ID: 922084

If continuation sheet Page 16 of 24

		AND HUMAN SERVICES				FORM	03/13/2024 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED					
		34G246	B. WING _			03/ [,]	12/2024			
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
KENWO	OD DRIVE HOME				04 KENWOOD DRIVE JRHAM, NC 27712					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
E 039 W 159	Based on document facility failed to ensi- community/facility-te tabletop exercise to Preparedness (EP) finding is: Review on 3/11/24 reviewed 10/27/23) community/facility-te tabletop exercise. Interview on 3/12/24 confirmed no full so exercise, mock drill conducted. QIDP CFR(s): 483.430(a) Each client's active integrated, coordina qualified intellectua This STANDARD is Based on record re Qualified Intellectua (QIDP) failed to ensi- treatment program the need for progra client's performance clients. The finding Review on 3/12/14 Program Plan (IPP) previous IPP dated objectives:	A with the Program Director cale community/facility-based or tabletop exercise had been of the facility's EP plan (last did not include a full scale based exercise, mock drill or 4 with the Program Director cale community/facility-based or tabletop exercise had been of the facility professional who- s not met as evidenced by: eview and interviews, the al Disabilities Professional sure client #6's active was monitored to determine m revision based on the e. This affected 1 of 3 audit is: of client #6's Individual 0 dated 1/23/24 and his 1/23/23 revealed the following	E 03							

If continuation sheet Page 17 of 24

STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/12/2024		
		34G246	B. WING				
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/12/2024		
KENWOOD DRIVE HOME				5004 KENWOOD DRIVE DURHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
W 159	 Client #6 will clos privacy with no mo the time Client #6 will iden coins (penny, nicket than 1 verbal prom Client #6 will verb of coins (penny, nicket than 1 verbal prom Client #6 will verb of coins (penny, nicket more than 1 verbal Additional review of progress after the objectives for a yea Interview on 3/12/2 the Program Direct would have been re objectives and writt no notes for the pro PROGRAM MONIT CFR(s): 483.440(f) The individual prog least by the qualifier professional and re but not limited to si successfully complidentified in the ind This STANDARD if Based on record re failed to ensure the was reviewed as ne successfully compliants 	e the bathroom door for re than 1 verbal prompt 85% of tify different denominations of el, dime, quarter) with no more pt 85% of the time alize different denominations ckel, dime, quarter) with no prompt 85% of the time f client #6's record did not the programs to determine client had trained on the ar. 24 with the current QIDP and tor indicated the previous QIDP esponsible for reviewing the ing progress notes; however, ograms could be located. FORING & CHANGE	W 15				

If continuation sheet Page 18 of 24

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/13/2024 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G246	B. WING			03/12/2024		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
KENWO	DD DRIVE HOME				004 KENWOOD DRIVE URHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 255 W 260	objective to maintai that are potentially f 12 months. Addition notes dated Januar only two documents August '23. B. Review on 3/11/2 10/17/23 revealed a behaviors per mont Additional review of January '22 - Decer documented behav Interview on 3/12/24 Disabilities Professi Manager confirmed current and have no completion. PROGRAM MONIT CFR(s): 483.440(f)(At least annually, th must be revised, as process set forth in This STANDARD is Based on record ref failed to ensure clie Plan (IPP) was revis affected 1 of 3 audi Review on 3/11/24 of an IPP dated 2/15/2 located. Interview on 3/12/24	n 0 rates of target behaviors issue damaging for 7 out of hal review of BSP progress y '22 - December '23 revealed ed behaviors for client #4 in 24 of client #6's BSP dated an objective to exhibit 0 target h for 7 out of 12 months. BSP progress notes dated mber '23 revealed only one ior for client #6 in August '23. 4 with the Qualified Intellectual ional (QIDP) and Home the BSP objectives remain of been reviewed for TORING & CHANGE	W 2					

		AND HUMAN SERVICES				FORM	03/13/2024 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G246	B. WING	i		03/	12/2024	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
KENWOO	DD DRIVE HOME				004 KENWOOD DRIVE DURHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 263	PROGRAM MONIT CFR(s): 483.440(f)(ORING & CHANGE (3)(ii)	W 2	263				
	are conducted only consent of the clien minor) or legal guar This STANDARD is Based on record re facility failed to ensu	s not met as evidenced by: eviews and interview, the ure written informed guardian ed for 2 of 3 audit clients (#4						
	Support Plan (BSP) objective to maintai that are potentially to 12 months. Addition the use of Risperda did not indicate writ	24 of client #4's Behavior) dated 4/1/23 revealed an in 0 rates of target behaviors tissue damaging for 7 out of nal review of the plan included al. Further review of the record ten informed consent for the nined from client #4's guardian.						
	10/17/23 revealed a behaviors (aggress behaviors) per mon months. Additional use of Klonopin and the record included the BSP signed by the consent form noted days." Further review	24 of client #6's BSP dated an objective to exhibit 0 target ion, disruption, other ath for 7 out of 12 consecutive review of the plan included the d Risperdal. Further review of a written informed consent for the guardian on 1/10/21. The I, "This consent expires in 365 aw of the record did not include formed consent for the BSP ardian.						
W 312	Disabilities Professi current BSP conser client #4 and client	4 with the Qualified Intellectual ional (QIDP) confirmed no nt had been obtained from #6's guardians.	W :	312				

Facility ID: 922084

If continuation sheet Page 20 of 24

		AND HUMAN SERVICES				FORM	03/13/2024 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED		
		34G246	B. WING			03/	12/2024	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
KENWO	DD DRIVE HOME				004 KENWOOD DRIVE DURHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
W 312	CFR(s): 483.450(e) be used only as an)(2) integral part of the client's	W 3	12				
	specifically towards elimination of the be are employed. This STANDARD is Based on record re facility failed to ensu (IDT) had considere elimination of restrict after a decrease in	plan that is directed the reduction of and eventual ehaviors for which the drugs s not met as evidenced by: eview and interviews, the ure the interdisciplinary team ed a reduction and/or ctive behavior medications target behaviors was cted 2 of 3 audit clients (#4 gs are:						
	Support Plan (BSP) objective to maintai that are potentially to 12 months. Addition the use of Risperda physician's orders of client ingests Rispe Risperdal .5 mg at 1 BSP progress notes December '23 revea behaviors for client the progress notes the IDT had conside elimination of the be the absence of targ B. Review on 3/11/2 10/17/23 revealed a behaviors per mont Additional review of Klonopin and Rispe	24 of client #4's Behavior) dated 4/1/23 revealed an in 0 rates of target behaviors tissue damaging for 7 out of nal review of the plan included al. Review of client #4's dated 9/27/23 revealed the erdal 1 mg every morning and bedtime. Further review of s dated January '22 - aled two documented #4 in August '23. Review of and the record did not indicate ered a reduction and/or ehavior medications based on let behaviors for 2 years. 24 of client #6's BSP dated an objective to exhibit 0 target th for 7 out of 12 months. f the plan included the use of erdal. Further review of client lers dated 9/27/23 revealed						

Facility ID: 922084

If continuation sheet Page 21 of 24

		AND HUMAN SERVICES			FORM	03/13/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		34G246	B. WING		03/12/2024	
NAME OF F	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
KENWO	DD DRIVE HOME			5004 KENWOOD DRIVE DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 312	the client ingests KI and Risperdal .5 mg BSP progress notes December '23 revea behavior for client # progress notes and IDT had considered elimination of the be the absence of targ Interview on 3/12/24 Disabilities Professi Director confirmed reduction or elimina for client #4 and clies significant decrease NURSING SERVIC CFR(s): 483.460(c) Nursing services m certified as not need review of their healt quarterly or more fr client need. This STANDARD is Based on record re facility failed to ensu- health status was c least a quarterly ba- clients (#4, #5 and a Review on 3/12/24 client #6's records of nursing assessment Interview on 3/12/24	lonopin 1 mg every evening g at bedtime. Further review of s dated January '22 - aled one documented 46 in August '23. Review of the the record did not indicate the d a reduction and/or ehavior medications based on et behaviors for 2 years. 4 with the Qualified Intellectual ional (QIDP) and Program the IDT had not considered a ation of behavior medications ent #6 based on their e in inappropriate behaviors. ES ((3)(iii) ust include, for those clients ding a medical care plan, a th status which must be on a equent basis depending on s not met as evidenced by: eviews and interviews, the ure a review of each client's ompleted by the nurse on at sis. This affected 3 of 3 audit #6). The findings are: of client #4, client #5 and did not include a quarterly	W 312			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION). 0938-039 [.] TE SURVEY			
	F CORRECTION	IDENTIFICATION NUMBER:		ING	· · ·	MPLETED			
		34G246	B. WING		03	/12/2024			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE				
KENWOO	DD DRIVE HOME			5004 KENWOOD DRIVE DURHAM, NC 27712					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE			
W 336	Continued From pa	ge 22	W 3	336					
	completing them fo	r any clients in the home.							
	confirmed quarterly requirement and them.	4 with the Program Director r nursing assessments are a e nurse should be completing							
W 369	DRUG ADMINISTR CFR(s): 483.460(k)		W 3	69					
	that all drugs, inclus self-administered, a This STANDARD i Based on observat interview, the facilit medications were a	are administered without error. s not met as evidenced by: tion, record review and y failed to ensure all administered without error.							
	in the home on 3/12 Technician (MT) mi Metamucil powder	s of medication administration 2/24 at 6:20am, the Medication xed two tablespoons of in a glass of water. Client #4 ure with his other medications.							
	orders signed 9/27/ "Natural Fiber powe	of client #4's physician's /23 revealed an order for, der, mix 1 rounded teaspoon in ake by mouth every day, 7am".							
MI 400	Manager) confirme tablespoons of the teaspoon as ordered			co					
VV 460	FOOD AND NUTR CFR(s): 483.480(a)		W 4	UO					

If continuation sheet Page 23 of 24

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/13/2024 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G246	B. WING			03/ [.]	12/2024
NAME OF F	PROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE		
KENWO	OD DRIVE HOME				004 KENWOOD DRIVE URHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 460	well-balanced diet i specially-prescribed This STANDARD is Based on observat interview, the facility received his specia indicated. This affect finding is: During breakfast ob 3/12/24 at 7:03am, fruit cup, milk, juice bagel with peanut b items were offered Review on 3/12/24 orders signed 9/27/ "Carnation breakfas 7am". Interview on 3/12/22 confirmed client #6	including modified and d diets. is not met as evidenced by: tions, record review and ty failed to ensure client #6 ally-prescribed diet as acted 1 of 3 audit clients. The bservations in the home on client #6 consumed cereal, a e and water. He refused his butter. No other food/drink at the breakfast meal. of client #6's physician's /23 revealed an order for st powder drink in the morning, 4 with the Home Manager freceives Carnation breakfast g; however, none was	W 4	60			

If continuation sheet Page 24 of 24