STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G189	A. BUILDING _____ B. WING _____	03/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-NASH HOUSE I	1045 KINCHEN DR ROCKY MOUNT, NC 27803

(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 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff were sufficiently trained on competencies directed towards client's health needs. This affected 1 of 3 audit clients (#2). The finding is: Nursing staff was not informed of client #2 missing a bowel movement for more than 3 days. Review on 3/4/19 of client #2's physician's order dated 1/31/19 revealed an order: "For constipation, if no BM in 3 days give dulcolax tabs 3 PO PRN q day X 2 days if no result, notify MD after checking for impaction." Further review of medication administration record (MAR) revealed no Dulcolax administered in the month of January and February and March 2019. Review on 3/4/19 of the client's 2019 bowel movement record revealed the client only had bowel movements recorded on 2/24 2/13, 2/3, 1/19, 1/14, and 1/11 in the month of January and February 2019. Review on 3/4/19 of client #2 Physician record of medical visit of 2/25/19 revealed. " ...constipation...monitor closely as it can trigger seizure." Interview on 3/5/19 with the facility's nurse confirmed she was not aware client #2's bowel	W 192		

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

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W 192	Continued From page 1 movements were not regular and staff were suppose to communicate with her if no bowel movement in 3 days.	W 192		
W 248	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on reviews and interviews the facility failed to ensure the client's individual plan was made available to all relevant staff, including staff of other agencies who work with the client. This affected 1 of 3 audit clients (#6). The finding is: Client #6 did not have a current individual program plan (IPP) available to at the day program. During review on 3/4/19 at the day program of client #6's record revealed no (IPP) available apart from the facesheet of the IPPs. During an interview on 3/5/19, the qualified intellectual disabilities professional (QIDP) confirmed the day program was in need of having the clients' current IPP .	W 248		
W 336	NURSING SERVICES CFR(s): 483.460(c)(3)(iii) Nursing services must include, for those clients certified as not needing a medical care plan, a	W 336		

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W 336	Continued From page 2 review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 4 audit clients (#6) received a review of their health status at least quarterly. The finding is: A quarterly nursing assessment was not completed as indicated for client #6. Review on 3/5/19 of client #6's record revealed he was admitted to the facility on 8/18/93. Additional review of the record indicated a nursing assessment had been completed on 1/31/19, 10/31/18 and 7/13/18; no other assessments could be located. Interview on 3/5/19 with the facility's nurse revealed the one quarterly nursing assessment was missing.	W 336		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician's orders were followed as written for 1 of 4 audit clients (#1). The finding is:	W 368		

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W 368	Continued From page 3 Physician's orders were not followed as indicated for client #1. During breakfast observations on 3/5/19 at approximately 8:08am, client #1 consumed his breakfast with his peer mate. During observations of medication administration in the home on 3/5/19 at approximately 8:38 am, client #1 ingested Omeprazole with 9 other pills. Review on 3/5/19 of client #1's physician's orders dated 1/31/19 revealed an order for, "Omeprazole 20mg: take 1 capsule by mouth twice a day." Further review of Omeprazole package from the pharmacy revealed a sticker which stated, "Take this medication before food." Interview on 3/5/19 with the nurse revealed, client #1 always gets his medication after breakfast. Interview on 3/5/19 with the qualified intellectual disabilities professional (QIDP) confirmed the physician's order was not followed.	W 368		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to prevent client #5 from eating food, with unwashed hands, after his hands had been in the trash can. The finding is: During observations on 3/4/19 at 11:53am, client	W 454		

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W 454	Continued From page 4 #5 was at the day program. Client #5, stood in the kitchen/dining room with bare hands, assisting staff with meal preparation. Client #5 was given verbal cues to carry dishes to the table for meal set up. As wrappers were removed from containers, staff gave the wrapper to client #5 and instructed client #5 to throw the item in the trash can. Client #5, who was the only client in the room, walked a few feet over to the trash can and put the wrapper in the trash can, that had a swing lid, and used his left hand, to push the wrapper all the way down inside of the can. When client #5 removed his hand from the trash can, client #5 was not observed washing his hands. Additional observations revealed staff then prompted client #5 to carry drink pitchers to the table, plastic bags full of food to each table, then instructed client #5 to be seated. Client #5's chair was located next to the trash can. Client #5 sat at the table, waiting for the other clients to wash their hands and sit at the tables. Before the meal began, client #5 was observed throwing two more disposable items into the trash can, touching the swing lid. Client #5 was not observed to get up to wash his hands. There were two other clients at the table with client #5. The clients ate family style and passed the packages of food around the table. Client #5 took the plastic bag of sandwich rolls, reached in the bag with his bare hands to get three rolls, before client #5 passed the bag to other clients. The other clients ate rolls from the bag that client #5 had touched with his unwashed bare hands. Interview with staff at the day program on 3/4/19 at 2:20pm, revealed that client #5 had washed his	W 454		

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W 454	Continued From page 5 hands before meal perpetration had started. The staff indicated that she had not had noticed client #5 placing his hand inside of the trash can, before client #5 ate his meal or handled the food.	W 454		