

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870	
(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 186	<p>DIRECT CARE STAFF CFR(s): 483.430(d)(1-2)</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to have sufficient staff on 2nd shift, to execute active treatment programs, assist with meal preparation, assist with toileting assistance and supervise clients, to prevent client to client physical altercations. This affected 3 of 5 audit clients (#2, #8 and #11). The finding are:</p> <p>Second shift staff were unable to keep all clients appropriately engaged in activity and provide visual supervision.</p> <p>a. During observations at the group home on 9/9/19 starting at 3:50 pm, there were two direct care staff in the home with six clients. Four of the clients were ambulatory and another client was able to self propel in wheelchair. Two of the clients (#2 and #9) were sitting in wheelchairs on the enclosed screen porch, another client (#8) was receiving toileting assistance at the rear of the house from staff C, whereas staff D remained in the activity room with clients (#5, #10 and #11) working on separate activities at the table. Staff D had already begun preparing dinner and invited client #10 to join her in the kitchen, to prepare for dinner, once client #8 and staff C re-entered the</p>	W 186		

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

TITLE

(X6) DATE

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: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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 186	<p>Continued From page 1 room at 3:59 pm.</p> <p>The observations continued with staff D and client #9 spending the majority of the next hour, removing food from the oven, processing the texture of the food for modified diets and setting the table. Client #2 remained sitting on the porch, not engaged in any meaningful activity, and was observed occasionally pulling at the waistband of her shorts and was repositioned in her chair by staff C, once.</p> <p>During review on 9/10/19 of client #2's behavior support plan (BSP) undated, revealed that she would receive positive reinforcement through opportunities for individual attention with a preferred staff each day to reinforce the absence of program target behaviors. Staff should first ask her if there's anything she wishes to do. This is to occur in the afternoon after she returns home for the day program site. A preferred staff member should be available to be with (client #2) during reinforcement period if the scheduling of this staff person allows.</p> <p>b. During observations in the group home, on 9/9/19 at 5:00 pm, staff D was in the kitchen finishing meal preparations and staff C begun to take client #8, then client #9 to the bathroom at 5:10 pm. Client #5 remained at the table in the activity room, looking through magazines. Client #11 came from the living room and went to the table where client #5 sat alone and snatched the magazines away, causing client #5 to have a verbal outburst. Neither staff was in the vicinity but could hear the outburst and called out to client #11, asking him, what he was doing. Neither staff left the kitchen or bathroom, to investigate what clients #5 and #11 were doing.</p>	W 186			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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 186	<p>Continued From page 2</p> <p>Client #11 became focused on taking the magazines away from client #5, who had been given a trash can by staff to clean up her area. Client #11 was observed coming back into the activity room from the living room, three times, to grab the magazine papers away from client #5. The last time the papers were grabbed, client #5 hit client #11 on his back. Client #11 did not retaliate against client #5, but hit client #8 in the groin, as client #8 walked into the room. When client #8 turned around to exit the room, client #11, shoved client #8 in his back. Neither staff were in the room to witness the incidents, redirect the clients, or physically intervene.</p> <p>During record review on 9/10/19 of client #11's individual personal plan (IPP) dated 11/29/18 revealed that client #11 depended on staff to intervene and help him display appropriate behaviors through the use of verbal and physical prompts.</p> <p>c. During observations in the group home on 9/9/19 at 5:20 pm, staff C brought client #2 to the dining room table in wheelchair, then repositioned client #2 who had slouched down in her chair. Client #2 became upset and struck staff #2, then began pounding her right fist on the wooden table, repeatedly. Client #2 continued to be agitated for the next 30 minutes, with no redirection from staff, who were assisting other clients with their meals. Client #2 would occasionally thrash her arms and struck client #11, sitting closest to her, several times.</p> <p>During record review on 9/10/19 of client #2's BSP revealed that client #2 had a goal to reduce frequency of agitation behavior and should be responded to by focusing on preventative</p>	W 186			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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 186	<p>Continued From page 3</p> <p>measures, positive behavior reinforcement, non-restrictive staff interventions when target behaviors occur. Targeted behaviors were described as vocal agitation and physical agitation that included thrashing her arms. Target behavior intervention procedures also included give her a verbal cue to stop the behavior. If she begins to display physical agitation behaviors as defined, proceed as follows. Repeat the verbal prompts, but this time pair with brief/light physical touch cues to stop or otherwise block the target behaviors. If she has thrown materials or is thrashing her arms, simply move her wheelchair to a distance away from any other loose material and from other consumers. If she continues to demonstrate agitation at this point, then the behavior interventions needs supersedes other aspects of her schedule. In this case, she will be offered the option to move to another (calmer) area with no demands.</p> <p>Interview with staff D on 9/9/19, revealed that two staff were assigned to work in the home on 2nd shift (3-11 pm) but sometimes they had a staff float between the two homes, giving them three staff.</p> <p>Interview with the director on 9/10/19, revealed that she had not received any complaints from staff regarding staffing concerns. The facility mainly used two staff per shift, but sometimes, there was a 3rd staff working, who floated between the two homes.</p> <p>Interview with the qualified individual developmental professional (QIDP) on 9/10/19, revealed that staff should contact her if they are unable to physically intervene to avoid physical altercations amongst clients.</p>	W 186			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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 214	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii)</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure an assessment occurred for 1 of 5 audit clients (#3) who was legally blind. The finding is:</p> <p>Client #3 did not have an assessment by services for the blind to see how the environment could be adapted or if technology, training or other personal supports would help staff assist him.</p> <p>Throughout observations on 9/9/19 and 9/10/19, client #3 ran into things with his wheelchair. At the day program, on 9/9/19, he was provided a Simon to tap the colors when they lit up and a paper to color during leisure. At meals on 9/9/19 and 9/10/19 he struggled to see his food and thanked one staff when she told him where something was. On 9/9/19 at dinner, he thought he was finished and said so. When staff said for him to finish his vegetable, he said he ate all of it and when it was pointed out to him he was thankful and ate the remainder.</p> <p>Review on 9/10/19 of client #3's individual program plan (IPP) dated 10/4/18, revealed he is legally blind in his left eye and has significant visual impairment in his right eye. The IPP did not indicate any instructions to staff as to how to assist him with his visual impairment.</p> <p>Interview on 9/10/19 with the qualified intellectual</p>	W 214			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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 214	Continued From page 5	W 214			
W 240	<p>disability professional (QIDP) revealed he had not had an assessment by services for the blind and would benefit from such an assessment.</p> <p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i)</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure the individual personal plan (IPP) for 1 of 5 audit clients (#8) included all relevant and specific information for staff to know how to assist the clients eat safely and independently. The findings is:</p> <p>The IPP for client #8 did not contain instructions for staff regarding the behavior of stealing fluids from other clients at meals.</p> <p>During lunch observation at the day program on 9/9/19 at 11:45 am, staff B provided client #8 with nectar thickened fluids at mealtime. During the meal, client #8 sat at a large square table with three other clients. Client #8 was able to stand and walk independently. Client #8 was observed standing and reached across the table and took the cup full of water from client #5 sitting across from him. Client #8 had the cup near his mouth, when staff A took it away from him.</p> <p>During dinner observation at the group home on 9/9/19 at 5:55pm, client #8 was observed to take a cup with fruit juice from client #9, after staff D left the dining room table to retrieve more nectar</p>	W 240			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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 240	Continued From page 6 thickened fluids for client #8. Staff C who remained at the table, quickly moved to client #8 to prevent him from drinking out of someone else's cup. An additional observation at 6:10 pm revealed that client #8 made another attempt to take a cup of water from client #5, who sat next to him, while client #5 was drinking. Staff D had to intervene to ensure that client #8 didn't drink thinned liquids. Client #8 then got up from the table, walked into the kitchen and opened the refrigerator and freezer; he did not find anything that interest him. Review on 9/9/19 of client #8's IPP dated 6/6/19 revealed that he had a history of aspiration pneumonia, which continued to be a risk for him and that he required nectar thick liquids. Staff were to assure his diet was followed to prevent aspiration. Interview on 9/10/19 with the management team, which encompassed the director, qualified intellectual developmental professional (QIDP) and the executive director (ED) revealed that client #8 did not have a formal goal for food stealing and that it was not defined as a targeted behavior in the BSP.	W 240			
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.	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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 7 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure a pattern of interactions supported the individual program plans (IPPs) in the areas of meaningful activities/choices, equipment guidelines (helmet and walker), and program implementation/integration. This affected 4 of 5 audit clients (#2, #3, #8 and #11). The findings are: 1. Client #3 was not encouraged to utilize his walker as per his IPP. Throughout observations on 9/9/19-9/10/19, client #3 was observed in a wheelchair and was not encouraged to use his walker. Review on 9/9/19 of client #3's IPP dated 10/4/18 revealed he should be encouraged to use a walker. Further review of client #3's most current physical therapy evaluation also noted "staff should encourage....as much mobility as able" to keep his strength in his legs. Interview on 9/19/19 with the qualified intellectual disabilities professional (QIDP) confirmed he should have been encouraged to use his walker. 2. During afternoon observations at the group home on 9/9/19 starting at 3:50 pm, client #2 remained sitting on the porch, not engaged in any meaningful activity, and was observed occasionally pulling at the waistband of her shorts. Client #2 had no contact from staff, except	W 249			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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	<p>Continued From page 8</p> <p>for repositioning in wheelchair. Client #2 became agitated being touched for repositioning, and had verbal outburst, pounded her fists on her body and wheelchair. At 5:20 pm, staff C relocated client #2 from the porch to the dining room table for dinner. During the meal, client #2 was able to feed herself independently and hold her cup, with minimum assistance by staff. Client #2 was still agitated and pounded her fist on table, and thrashed her arms, hitting client #11 on his right arm. Client #2 was not given verbal instructions to stop hitting nor was she moved away from others, to avoid contact. Also, client #2 was not prompted to wipe her mouth during the meal and was permitted to roll away from the table, afterwards, without prompting from staff to put her cup in the bin.</p> <p>During morning observations at the group home on 9/10/19 starting at 8:00 am, client #2 displayed agitation throughout her meal but was able to feed herself and hold a cup to drink fluids. During the meal, staff did not prompt client #2 to wipe her mouth. After the meal, client #2 rolled away from the table, without any verbal prompts to place her cup in the bin.</p> <p>During record review on 9/10/19 of client #2's behavior support plan (BSP) revealed that client #2 had a goal to reduce frequency of agitation behavior and should be responded to by focusing on preventative measures, positive behavior reinforcement, non-restrictive staff interventions when target behaviors occur. Targeted behaviors were described as vocal agitation and physical agitation that included thrashing her arms. Target behavior intervention procedures also included give her a verbal cue to stop the behavior. If she begins to display physical agitation behaviors as</p>	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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	<p>Continued From page 9</p> <p>defined, proceed as follows. Repeat the verbal prompts, but this time pair with brief/light physical touch cues to stop or otherwise block the target behaviors. If she has thrown materials or is thrashing her arms, simply move her wheelchair to a distance away from any other loose material and from other consumers. If she continues to demonstrate agitation at this point, then the behavior interventions needs supersedes other aspects of her schedule. In this case, she will be offered the option to move to another (calmer) area with no demands. Also a component of client #2's BSP allowed for positive reinforcement through opportunities for individual attention with a preferred staff each day to reinforce the absence of program target behaviors. Staff should first ask her if there's anything she wishes to do. This is to occur in the afternoon after she returns home for the day program site. A preferred staff member should be available to be with (client #2) during reinforcement period if the scheduling of this staff person allows.</p> <p>An additional review on 9/10/19 of client #2's individual personal plan (IPP) dated 1/31/19, revealed that she was able to clear table and throw her trash away with staff cues. She also had training goals to put her cup in the bin and to wipe her mouth with a tissue with manipulations.</p> <p>During an interview with the qualified individual developmental professional (QIDP) on 9/10/19 revealed that client #2 had a BSP and that staff should practice training goals of placing cup in bin, tolerating tooth brushing and wiping mouth with tissue at all opportunities.</p> <p>3. During observations in the group home, on 9/9/19 at 5:20 pm, client #11 sat at the dining</p>	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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	<p>Continued From page 10</p> <p>table to eat dinner and was able to feed himself independently. The dinner menu included pork loin, cabbage and tater tots. Client #11 had a spoon placed on the left side of his plate, but didn't use it; instead client #11 chose to feed himself at a rapid pace, using only his fingers to pick up the food. Client #11 was observed picking a thick whole piece of pork loin, placing it between his teeth, then using his right hand, to pull the meat out of his mouth, in order to get smaller pieces to chew. Client #11 had a great deal of spillage on the table, floor and in his chair during his meal and wanted extra portions of food. Staff C gave client #11 an extra serving of cabbage, then both staff C and D, reminded client #11 to use his spoon, after he started out to use his fingers again.</p> <p>During observations in the group home, on 9/10/19 at 8:00 am, client #11 sat at the dining table to eat breakfast. He was served dried cereal and ate it with his fingers, instead of using a spoon. Client #11 was not prompted by staff to use his spoon.</p> <p>During record review on 9/10/19 of client #11's IPP dated 11/29/18 revealed that client #11 refused to use a fork or have staff attempt to use manipulation with a fork. Client #11 would use a spoon, when he wanted too. Client #11 would receive verbal cues from staff to use his utensils since client #11 preferred to eat with his fingers.</p> <p>During an interview on 9/10/19 with the QIDP, she revealed that staff should encourage client #11 to slow down and use a spoon.</p> <p>4. During observation at the day program on 9/9/19 from 11:45 am until 12:20 pm, staff B</p>	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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 11 assisted client #8 with lunch, but did not ensure that his helmet was removed during the meal. During review on 9/9/19 of client #8's IPP, dated 6/6/19, it revealed that client #11 had a history of agitation behaviors and hitting his head on the wall. Client #8 would wear a soft helmet to prevent injury to head, from self-injurious behaviors (SIB) with the exception of allowing 2 hour blocks of removal and removing the helmet at meals and snacks for 30 minutes. During an interview with staff C on 9/9/19, she commented that per client #2's plan, his helmet was removed for snacks and meals. During an interview with the director on 9/10/19, it was confirmed that client #2 should not wear his helmet at meals.	W 249			
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interview the facility failed to follow dietary orders for 1 of 5 audit clients (#2). The finding is: Client #2 did not receive 8 ounces of prune juice at each meal. a. During lunch observation at the day program on 9/9/19 from 11:45 am to 12:20 pm, client #2 did not receive any prune juice with her meal. The	W 460			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2019
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(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 460	<p>Continued From page 12</p> <p>clear shipping container that was sent from the group home to the day program, containing the clients' meals, also did not have any visible containers of prune juice.</p> <p>b. During dinner observation at the group home on 9/9/19 from 5:30 pm to 6:10 pm, client #2 did not receive any prune juice with her meal.</p> <p>Record review on 9/9/19 of client #2's individual personal plan (IPP) dated 1/31/19, revealed due to a history of chronic constipation, she needed to receive 8 ounces of prune juice with each meal.</p> <p>Interview on 9/10/19 with the director, revealed that staff were expected to give client #2 prune juice at meals. The director added that client #2 did not have a history of refusing prune juice and it was available in their food inventory.</p>	W 460		