	-	ID HUMAN SERVICES			FOR	M APPROVED	
			0.0			<u>D. 0938-0391</u>	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED R		
	34G275		B. WING			R / 14/2019	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SCI-ROAN	IOKE HOUSE			103 & 105 CLEARFIELD DRIVE			
OOHIOAN				ROANOKE RAPIDS, NC 27870			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		COMPLETION DATE	
110		,		DEFICIENCY)			
W 000	INITIAL COMMENTS		W 00	00			
	A revisit was conduct	ted on 11/14/19 for all					
	•	cited on 9/5/19. Corrected					
	deficiencies W186 an						
W 111	corrected, with new n CLIENT RECORDS	oncompliance lound.	W 1 ⁻	11			
VV 111	CFR(s): 483.410(c)(1)	VV I				
		,					
	The facility must deve	•					
		n that documents the client's					
	and protection of the	eatment, social information,					
		chefit à righta.					
	Based on observatio	not met as evidenced by: ns, record reviews and r failed to assure the record					
		fected 1 of 6 audit clients					
1	Client #12's adaptive inaccurate information	behavior scale contained n.					
	survey, client #12 wa with preparing the bre	on 11/14/19 at the follow-up s observed assisting Staff F eakfast meal. Throughout t #12 was observed to stir					
		s with staff assistance,					
	-	r trash away in the trash can,					
	scoop coffee and put	it in the coffee filter, assist					
		and biscuits and gravy, and					
	press buttons on the	conee pot.					
	Review on 11/14/19 c	of client #12's adaptive					
		10/5/19, sections on food					
		ral domestic activities,					
		12 does not have meal					
	preparation skills and	general domestic activity					
	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE		(X6) DATE	

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

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/03/2019 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE COMF	SURVEY PLETED	
		34G275	B. WING				R 14/2019
NAME OF PI	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SCI-ROANOKE HOUSE					103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
W 111	Continued From page skills.	: 1	w	111	1		
	she enjoys working a	with client #12 revealed that nd helping in the kitchen. favorite thing to do is "cook, n and sausage."					
{W 240}			{W 2	240}	}		
	The individual program	n plan must describe to support the individual					
	Based on observatio interviews, the facility on individual program independence for 2 o audited. The findings						
	1. Client #8's IPP did allow training for mea	not include any language to I preparation skills.					
	11/14/19 at 8:00 am, independently in the l food in a blender for o walked into the dining at the table and scrap the blender onto the p	kitchen and was pureeing client's breakfast. Staff A room, approached client #8 ed pureed contents from plate, that was served to #8 finished breakfast, he					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/03/2019 1 APPROVED 9. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G275	B. WING				` 14/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST				
SCI-ROAN	NOKE HOUSE			103 & 105 CLEARFIELD DI ROANOKE RAPIDS, NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{W 240}	Review of the undated (ABS) on 11/15/19 rev have food preparation clearing goals. In othe #8 had strengths in pu- help, washes hands v supervision and untier assistance. During an interview w regarding client #8's r explained that client # for meal prep tasks. In had the skills to press appliance, transfer foo hand over hand assiss for staff to allow him to preparation and expla 2. During observation was observed assistin breakfast meal. Thro client #12 was observ bowls with staff assist trash away in the tras it in the coffee filter, a and biscuits and grave coffee pot. Review on 11/14/19 of 10/10/19 revealed no program to foster clien preparation. Review on 11/14/19 of behavior scale, section general domestic actin	d adaptive behavior scale vealed that client #8 did not in goal, table setting or table er areas on the ABS, client utting on clothes without without help, brush teeth with s shoelaces without with the director on 11/14/19 meal preparation skills, she 48 was too easily distracted Director shared that client #8 is a button to operate an od onto a plate with some tance. Her expectation was o assist with the meal ain what they are doing. Is on 11/14/19, client #12 ing Staff F with preparing the ughout the observation, ved to stir food in pots and tance, modify biscuits, throw is can, scoop coffee and put issist with cooking oatmeal y, and press buttons on the of client #12's IPP dated training or active treatment int #12 in the area of meal	{W 240}					

Facility ID: 944940

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G275				≺ 14/2019		
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-		
SCI-ROAN	OKE HOUSE				03 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{W 240} W 435	she enjoys working an Client #12 stated her especially eggs, baco Interview on 11/14/19 client #12 enjoys help meals for the home. Interview on 11/14/19 that she had been so assessments for othe that she had been so assessments for othe that she had not had the needs. SPACE AND EQUIPM CFR(s): 483.470(g)(1 The facility must prove equipment in dining, I recreation, and progra adequately equipped hearing and other eval conducted in the facilit clients with needed se subpart and as identifip program plan. This STANDARD is r Based on observation failed to provide suffic adaptive equipment in clients (#12). The find Client #12 was unable meal preparation.	 with client #12 revealed that nd helping in the kitchen. favorite thing to do is "cook, in and sausage." with Staff F revealed that bing staff with preparing with the director revealed focused on getting other r individual's in the home time to focus on client #12's MENT) ide sufficient space and iving, health services, ram areas (including and sound treated areas for aluations if they are ity) to enable staff to provide ervices as required by this fied in each client's individual 	{W 2	435				

Facility ID: 944940

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 12/03/2019 1 APPROVED 2: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G275	B. WING		_	F 11/'	२ 14/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SCI-ROAN	IOKE HOUSE			03 & 105 CLEARFIELD DR OANOKE RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 435	preparing breakfast fr At 7:37am, client #12 from the coffee tin inte #12 was unable to rea- leg rests on her whee counter. Staff F was rests to the side to try was still unable to. S hold the tin of coffee i the coffee filter. Client into the filter and the coffee pot. Client #12 on the coffee pot but until the staff moved i hit the on button. At #12 to assist with stirr However, client #12 of Staff F was observed client #12 was able to wanted to put the wat oatmeal. However, cl reach the sink. Staff bowl in client #12's la pitcher to pour into the Interview on 11/14/19 she likes to help in the her favorite thing to de bacon and sausage b because it to tight and Interview on 11/14/19 client #12 enjoys help meals for the home a it is hard. Staff F stat the bowls and things of the counters are too h	e 4 s observed to assist with om 7:35am until 8:30am. wanted to scoop the coffee of the coffee filter. Client ach the counter due to the lchair and the height of the observed to swing her leg to get client #12 closer but taff F then had client #12 n her lap and the staff held at #12 scooped the coffee staff put the filter in the 2 asked to press the buttons was unable to reach the pot t from the counter to let her 7:52am, Staff F asked client ing the sausage gravy. ould not reach the pot. to put the pot in her lap and o stir. At 8:04am, client #12 er in the bowl to make lient #12 was not able to F was observed to put the p and gave her water from a e bowl to stir the oatmeal. with client #12 revealed that e kitchen. Client #12 stated to is "cook, especially eggs, ut sometimes it is hard d she can't reach things." with Staff F revealed that ing staff with preparing nd helping in the kitchen but ed that is why she has to put down to client #12 because high, the kitchen is so tight, not reach things. Staff F	W 435				

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING			LETED
		34G275	B. WING				२ 14/2019
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	14/2013
SCI-ROAN	IOKE HOUSE				03 & 105 CLEARFIELD DRIVE		
			ID	R	OANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 435	Continued From page	Σ.E.		105			
VV 435	Continued From page	only stands to transfer with	W 4	135			
		e is unable to even stand					
	for short periods of tir	ne to get up to the counters.					
	Interview on 11/14/19	with the director revealed					
		to look at getting some					
	o 1	something to help client #12 chen. The director stated					
		focused on getting other					
		r individual's in the home time to focus on client #12's					
	needs.						
{W 460}	FOOD AND NUTRITI CFR(s): 483.480(a)(1		{W 4	60}			
	Each client must rece well-balanced diet inc	•					
	specially-prescribed of	-					
	Based on observation	not met as evidenced by: ns, record reviews and failed to follow dietary orders (#2, #4 and #7). The					
	Staff did not follow die prune juice serving at	etary order for prescribed meal.					
	11/14/19 from 8:00-8: an 8 ounce glass with Client #2 independen prune juice, before fin the table. In addition, card for each client. C	oservations in the home on 30 am, Staff C halfway filled a prune juice for client #2. tly drunk 3 ounces of the hishing her meal and leaving on the table, was a meal On client #2's meal card, it ceive 8 ounces of prune					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391	
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	A. BUILDING			PLETED	
		34G275	B. WING			R 11/14/2019		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	14/2013	
SCI-ROAN	IOKE HOUSE				03 & 105 CLEARFIELD DRIVE			
				F	ROANOKE RAPIDS, NC 27870			
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
{W 460}	Continued From page	96	{W 4	60}				
	Review on 11/14/19 of the November 2019 physician's orders for client #2 revealed that she would receive 8 ounces of prune juice with each meal, for constipation.							
	During an interview w revealed that client #2 ounces of prune juice was standing nearby #2's prune juice order nurse had commente dealing with bowel iss with medications adju expressing pain and o in her stool formation							
	2. Client #4 and client juice at breakfast.	t #7 did not receive prune						
	during the follow-up s observed eating brea	kfast from 8:30am until luring the observation of						
	displayed in the dining	7 should receive 4 ounces of						
	that the diet roster dis most current diet. Th	with the director revealed splayed in the home is the e director confirmed that received prune juice with						
	b. During breakfast ol	bservations on 11/14/19						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 12/03/2019 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED		
		34G275	B. WING			F 11/'	२ 14/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SCI-ROAN	IOKE HOUSE			103 & 105 CLEARFIELD D ROANOKE RAPIDS, NO			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BI		COMPLETION DATE
{W 460}	Continued From page	o 7	{W 46	1			
(11.100)	during the follow-up s		100-00	51			
	observed eating brea	kfast from 8:30am until					
	client #4 given prune	luring the observation was juice.					
	Review on 11/14/19 c	of diet roster (undated)					
	displayed in the dinin	g room of the home 4 should receive 4 ounces of					
	prune juice at each m						
	Interview on 11/14/19	with the director revealed					
	that the diet roster dis	splayed in the home is the					
		e QIDP confirmed that client ved prune juice at breakfast.					

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