

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

PRINTED: 09/18/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/16/2020
NAME OF PROVIDER OR SUPPLIER SCI-TRIANGLE HOUSE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1523 TYONEK DRIVE DURHAM, NC 27703		
(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 000	INITIAL COMMENTS	W 000			
W 369	<p>A complaint survey was conducted at the facility on 9/16/20 for intake NC00165657. One deficiency was cited as a result of the survey.</p> <p>DRUG ADMINISTRATION CFR(s): 483.460(k)(2)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered without error. This affected 1 of 2 clients (#3) observed receiving medications. The finding is:</p> <p>Client #3 did not receive all medications as ordered.</p> <p>During observations of medication administration in the home on 9/16/20 at 8:02am, client #3 ingested Zyrtec 10mg, Kapvay .1mg, Vitamin D3 2000 IU, Singulair 10mg, Ativan 2mg, Luvox 50mg, Lamictal 200mg, Tegretol ER 200mg, Depakote 250mg, Depakote 500mg, and Lithium Carb 450mg. The client also received one Cosopt eye drop in her left eye.</p> <p>Review on 9/16/20 of client #3's physician's orders dated 9/1 - 9/30/20 (signed 9/8/20) revealed orders for Flonase 50mcg, place 2 sprays in each nostril every day, 7a; Miralax powder, mix one capful (17 grams) 18 oz of beverage of choice 3 times a week, M-W-F, 7a; and Systane eye drops 0.1/0.4, place 1 drop in</p>	W 369			

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.

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

PRINTED: 09/18/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/16/2020
NAME OF PROVIDER OR SUPPLIER SCI-TRIANGLE HOUSE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1523 TYONEK DRIVE DURHAM, NC 27703		
(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 369	Continued From page 1 each eye 4 times daily, 7a, 12p, 4p, 8p. During an interview on 9/16/20, the medication technician acknowledged the Miralax, Flonase and Systane eye drops were not given during the morning medication administration. Interview on 9/16/20 with the facility's nurse confirmed client #3's physician's orders were current and she should have received all medications as ordered.	W 369			