STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G214	A. BUILDING _____ B. WING _____	C 09/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-TRIANGLE HOUSE II	**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 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.	W 000		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. 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: Client #3 did not recieve all medications as ordered. 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. 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	W 369		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G214	A. BUILDING _____ B. WING _____	C 09/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-TRIANGLE HOUSE II	**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		