DEPART	DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED										
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED						
		34G275	B. WING		R-C 06/04/2021						
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE							
SCI-ROANOKE HOUSE				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	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	HOULD BE COMPLETION						
W 000	INITIAL COMMENTS		W 00	W 000							
W 382	A revisit and complaint survey was completed on 6/4/21 for Intake #NC00177273 and Intake #NC00177360. No deficiencies were cited for the complaints. Seven deficiencies were corrected for the revisit; However, one deficiency remains out of compliance. The facility remains out of compliance. DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(I)(2)		W 38	2							
	The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure all medications were kept locked except when being administered. The finding is:			W382 In the future, all drugs and biological stored in a locked container for trans Medication will also be stored in a locked cabinet while a Day Program.	sport.						
				The Director and RN Team leader w provide trainingto all nurses and med monitors on Nursing Policy 206-010 Medication L Storage and Disposal, and Nursing p	_abeling,						
	During observations of medication administration on 6/4/21 at 12:15pm, Staff A retrieved			to address medication transport.							
	have a lock on it. In on a table in the root	gray laptop bag that does not addition, the bag was laying om where medication is has a door that does not lock.		The Director will monitor medication At the day program twice weekly. The RN Consultant will monitor med							
				Administration once weekly.	oation						
	several weeks, meet transported from the	with Staff A revealed that for dications have been e home to the day program in ot lock. In addition, Staff A		The Executive Director will monitor Medication Administration at the Day program once monthly.							
		where the bag is kept does		All monitoring will be documented. Any concerns will be followed up on.							
	medications are tra	with Staff B revealed that nsported in the laptop bag that ept in a room that does not									
ABORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	TITLE	(X6) DATE							

slie

oudita

Chief Operations Officer- Eastern Region

6/11/2021

PRINTED: 06/09/2021

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.

DEPART CENTE	PRINTED: 06/09/2021 FORM APPROVED OMB NO. 0938-0391								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
34G275		34G275	B. WING			R-C 06/04/2021			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			<u> </u>			
SCI-ROANOKE HOUSE				103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
W 382	lock while at the da that previously, they was used to transpo- nurse has provided bag. In addition, St to be a cabinet that where medications no longer there. Interview on 6/4/21 revealed that medic transported in a loc at the day program director confirmed t	ge 1 y program. Staff B revealed y had a red bag that locks that ort medications but the facility them with the gray laptop aff B revealed that there used locked at the day program were kept but the cabinet was with the facility Director cations are supposed to be ked bag and kept in a cabinet that locks. The facility the medications should be a until they are administered.	W 3	82					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 944940

If continuation sheet Page 2 of 2