STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G261	A. BUILDING _____ B. WING _____	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-EAST	338 COOPER DRIVE WINTERVILLE, NC 28590

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure privacy during personal care for 1 of 5 audit clients (#8). The finding is: During morning observations in the home on 9/8/21 at 7:12am, client #8 entered the bathroom, undressed and got into the shower. Client #8 did not shut the bathroom door or pull the shower curtain closed. At 7:17 am, client #8 walked out of the bathroom still undressed and went down the hallway to the laundry room and back to the bathroom. Client #5 still did not close the door. At 7:22am another client went into the bathroom with client #8 and washed her hands. Client #8 was still partially undressed at this time. At no time was client #8 prompted to close bathroom door for privacy. During this time one staff member was assisting a client with hygiene, another staff member was in the kitchen and two staff members were in the living room area. Record review on 9/9/21 of client #8's Individual Program Plan (IPP) dated 4/22/21 did not include any goals or training related to privacy. During an interview on 9/8/21, staff C stated client #8 is supposed to have staff on the hallway when she is performing her activities of daily living due to lack of understanding the need to protect her privacy.	W 130	W130 An interim core team meeting will be held to discuss the best method to address client #8's needs in the privacy area. A training goal will be developed and all personnel in-serviced. All personnel will receive training regarding clients' right to privacy and how to assure privacy for all clients in various situations in the ICF/IID facility. The Director or PC will monitor programs to assure client privacy three times weekly. The RQP will monitor programs for privacy twice monthly. The Executive Director (Corporate Office) will monitor programs once monthly. All monitoring will be documented. Any concerns will be followed up on. DHSR - Mental Health SEP 29 2021 Lic. & Cert. Section	11-8-2021

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

Sesue Rasuten — Chief Operations Officer- Eastern Region — 9-17-2021

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.

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W 130	Continued From page 1 During an interview on 9/8/21, the home supervisor (HS) confirmed client #8 regularly does not close doors and walks out of the bathroom undressed. The HS confirms staff should have been present.	W 130		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure 1 of 5 audit clients (#10) had the right to appropriate fitting clothing. The finding is: During observations throughout the survey on 9/7/21 in the home and at the day program client #10's shorts were seen hanging on his hips. Further observations revealed client #10's underwear was visible on several occasions as his walked around and when he went outside at the day program. Client #10 was observed holding the side of his shorts while he was walking. When client #10 sat down in a chair at the day program to eat his lunch both his pants and underwear where below his hips and his buttocks was visible. Additional observations revealed client #10 was wearing a belt. At no time was client #10 prompted to adjust his belt or shorts. Review on 9/8/21 of client #10's individual	W 137	W137 Client #10 will be provided with appropriately fitting clothing. Additionally, an interim core team meeting will be held to discuss client #10's needs in the area of dressing and clothing. The team will develop a plan for any identified needs in this area and all staff will be in serviced. All clients clothing will be assessed for proper fit and clothing needs will be addressed. All staff will receive training on client rights and the right to retain appropriate clothing. The Director or PC will monitor programs to assure client rights and appropriate clothing needs are met three times weekly. The RQP will monitor programs twice monthly. The Executive Director (Corporate Office) will monitor programs once monthly. All monitoring will be documented. Any concerns will be followed up on.	11-8-2021

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W 137	Continued From page 2 program plan (IPP) dated 3/4/21 stated, "...does require some assistance from staff to perform most of his self-help needs such as dressing...." Review on 9/8/21 of client #10's habilitation technician evaluation dated 2/22/21 revealed, "Puts on belt (Total Physical Assistance/Manipulation)." During an interview on 9/8/21, the qualified intellectual disabilites professional (QIDP) confirmed client #10 needs verbal and physical prompting to ensure his clothing is fitting properly.	W 137		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure relevant interventions or goals were addressed in the individual program plan (IPP). This affected 1of 5 audit clients (#8). The finding is: During observation on 9/8/21, at 7:12am client #8 showered with the bathroom door opened and did not pull the shower curtain closed. At 7:17am client #8 walked down the hallway to the laundry room and back to the bathroom undressed. At 7:22am another client entered the bathroom with client #8 to wash her hands, client #8 was still partially undressed at this time. Review of client #8's record on 9/8/21 revealed	W 240	W240 The interdisciplinary team will meet to discuss the best method to address client #8's needs in the privacy area. A training goal will be developed and incorporated into the IPP. All personnel will be in-serviced on the interventions. The Interdisciplinary Team will assure that all clients that have needs in the area of privacy have interventions in the IPP to support independence in these areas. Any need objectives will be developed and in serviced to all staff. The RQP will assure that the Interdisciplinary team addresses privacy needs annually at each PCP meeting. The Executive Director (Corporate office) will monitor PCP plans as needed to assure that privacy needs are addressed for each client.	11-8-2021

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W 240	Continued From page 3 an individual program plan (IPP) dated 4/22/21. The IPP did not indicate an active plan to address privacy issues. During an interview on 9/8/21, the home supervisor (HS) confirmed client #8 regularly does not close doors and walks out of the bathroom undressed. The HS confirms goals and trainings should be implemented in the IPP.	W 240		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review, documentation and interviews, the facility failed to ensure data was documented correctly. This affected 1 of 5 audit clients (#10). The finding is: During observations at the day program on 9/7/21 at 11:48am, client #10 banged the back of his head three times on a wall by the front door. Client #10 slapped the left side of his face three times with his open hand. At 12:02pm client #10 used his elbow to hit a picture hanging on the wall. Client #10 exited the day program at 12:03pm, though the front door and went to the back of the building. At 12:06pm, client #10 exited the side door and went to the facility's transport van. Client #10 used his closed fist to bang on a table as he walked by. Client #10 was observed exiting the building at 12:08pm at	W 252	W252 All staff will be retrained on client #10 and all clients Behavior Intervention Plan and the documentation data requirements of that plan. The Director or PC will monitor Behavior Intervention Programs and documentation data three times weekly. The RQP will monitor data documentation twice monthly. The Executive Director (Corporate Office) will monitor data documentation once monthly. All monitoring will be documented. Any concerns will be followed up on.	11-8-2021

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W 252	Continued From page 4 running to the facility's transport van. At 12:12pm, client #10 hit a picture hanging on a wall and then hit the paper towel dispenser with a closed fist. At 12:16pm, client #10 exited the side door of the day program and ran to the facility's transport van. Client #10 exited the day program at 12:17pm and again ran up the facility's transport van and pulled on the door handle. At 12:22, client #10 slapped the left side of his face three times with his open hand. After eating lunch at 12:40pm, client #10 slapped the right side of his face twice with his open hand. Each time client #10 exited the day program, staff were able to redirected him back into the building. Review on 9/8/21 of client #10's behavior data sheet for 9/7/21 revealed his behaviors were not documented.. Review on 9/8/21 of client #10's behavior intervention plan (BIP) dated 2/18/21 revealed, "DATA COLLECTION: Staff should record behaviors noting the date and time according to the codes listed in the behavior data sheet." Further review revealed client #10's target behaviors are: Inappropriate Behavior, Aggression, Destruction, Wetting Self and Elopement. During an interview on 9/7/21, Staff D stated client #10 does have behaviors; but with the surveyors being here he is doing "a little more." During an interview on 9/8/21, Staff A revealed client #10 does have a behavior intervention plan. Further interview revealed when client #10 has a behavior, it is documented on his behavior data sheet. Additional interview revealed client #10 target behaviors are self injurious behaviors,	W 252		

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W 252	Continued From page 5 falling on the floor and cursing. During an interview on 9/8/21, Staff B stated client #10's behavior data sheet should be filled out whenever he has a behavior. Further interview revealed it should be filled out as soon as possible or before the end of the shift. During an interview on 9/8/21, the qualified intellectual disabilities professional (QIDP) confirmed client #10's behavior data sheet should have been filled out to reflect his target behaviors.	W 252		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, documentation and interview, nursing services failed to ensure that staff were sufficiently trained in the taking the temperature of visitors in regards to COVID-19 protocol. This potentially effected all clients (#1, #2, #3, #4, #5 and #6) residing in the facility. The finding is: During morning observations in the home on 9/7/21 at 9:32am, the surveyor entered the home. Further observations revealed Staff D who opened the door did not take the temperature of the surveyor. Staff D did not ask the surveyor any questions regarding COVID-19 protocol.	W 340	W340 The RN Team Leader and Facility Director will provide training to all staff on current COVID-19 protocols and the SCI Pandemic plan. This will include training on taking temperatures of all staff and visitors upon entry, as well as screening protocols. The RN Team leader and the Facility Director will assure staff are trained on other relevant health and hygiene methods. The Director or PC will monitor COVID-19 health and hygiene protocols three times weekly. The RN team leader will monitor COVID-19 health and hygiene protocols twice monthly. The Executive Director (Corporate Office) Will monitor COVID-19 health and hygiene protocols once monthly. All monitoring will be documented. Any concerns will be followed up on.	11-8-2021

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W 340	Continued From page 6 Further observations revealed a thermometer on a table by the front door. During an interview on 9/8/21, Staff A stated, "All visitors are to have their temperature taken prior to entering the home." Review on 9/7/21 of the facility's Emergency Prepardness (revision date 1/22/21) revealed, "Core Infection Prevention Practices for ALL Locations: 1. Staff, Visitors...Screening: 1. All persons entering any SCI building will complete a screening questionnaire and temperature check daily...." During an interview on 9/8/21, the home supervisor (HS) revealed all visitors are to have their temperature taken before entering the home. During an interview on 9/8/21, the qualified intellectual disabilities professional (QIDP) confirmed all visitors are to have their temperature taken before they enter the home.	W 340		
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by:	W 342		

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W 342	Continued From page 7 Based on observations and interviews, the facility failed to ensure staff were sufficiently trained in reporting medical concerns. This affected 1 of 5 audit clients (#10). The finding is: During afternoon observations at the day program on 9/7/21 at 11:48am, client #10 sat down in a chair located near the front door and banged the back of his head three times against the wall; while a staff person was standing near him. At 12 noon, client #10 told Staff D that his head was hurting. Staff D placed her hand on his forehead and said, "You feel just fine." At no time was client #10 further assessed about his head hurting. Review on 9/8/21 of the facility's policy of Pain Management (date reviewed 9/12) stated, "Policy: Clients exhibiting signs of pain/discomfort, complaining of pain/discomfort or who have an illness/condition that generally causes pain, will have their pain assessed and managed." During an interview on 9/8/21, the facility's nurse revealed the on-call nurse should have been called about client #10 saying how his head hurts. Further interview revealed the on-call nurse would have given further instructions to the staff on what to do. During an interview on 9/8/21, the qualified intellectual disabilities professional (QIDP) stated the staff should have called the on-call nurse for further instructions regarding client #10 stating how his head was hurting.	W 342	W342 The RN team leader will provide training to all staff on detecting signs and symptoms of illness or dysfunction, meeting the health needs of the client, and reporting medical concerns. The RN team leader will assure that all staff demonstrate competency in this skill. All staff will receive training on: • guidelines for reporting incidents, or symptoms to medical staff • assessing clients after an injury • contacting the on call nurse to report pain or discomfort The Director will monitor medical reporting once weekly. The RN team leader will monitor medical reporting twice monthly. The Executive Director (Corporate Office) will monitor medical reporting once monthly. All monitoring will be documented. Any concerns will be followed up on.	11-8-2021
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)	W 436		

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W 436	Continued From page 8 The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure recommended equipment, specifically eyeglasses, were furnished for 1 of 5 audit clients (#11). The finding is: During observations in the home on 9/7/21, client #11 was not observed wearing his eyeglasses in the home and the day program. Client #11 was observed playing a variety of table top games; including a matching game and watching television. Further observations on 9/27/21 at 4:27pm, client #11's eyeglasses were observed on the dresser in his bedroom. At no time was client #11 prompted to wear his eyeglasses. During a review on 9/8/21 of client #11's individual program plan (IPP) dated 2/18/21 stated, "[Client #11] does wear eyeglasses throughout the day." During a review on 9/8/21 of client #11's vision examination dated 5/18/21 revealed, "usage: full time wear." During an interview on 9/8/21, the home supervisor (HS) revealed client #11 "Probably does need to be verbally prompted to wear his eyeglasses."	W 436	W436 The interdisciplinary team will meet to discuss client #11's needs in the area of eyeglasses usage. Interventions will be developed and incorporated into the IPP. All personnel will be in-serviced on the interventions. The Interdisciplinary Team will assure that all clients that have needs to support the use of devices (eyeglasses, hearing or communication aids, dentures, braces, etc.) are addressed in the IPP. Any needed objectives will be developed and all staff will be in-serviced. The Director or PC will monitor programs for eyeglasses and device usage three times weekly. The RQP will monitor programs for eyeglasses and device usage twice monthly. The Executive Director (Corporate Office) will monitor programs for eyeglasses and device usage once monthly. All monitoring will be documented. Any concerns will be followed up on	11-8-2021

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W 436	Continued From page 9 During an interview on 9/8/21, the qualified intellectual disabilities professional (QIDP) confirmed client #11 should be wearing his eyeglasses during awake hours.	W 436		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11 and #12.) residing in the two homes. The findings are: A. Review of fire drill reports for House 1 on 9/7/21 revealed the following: Five drills were conducted on third shift: 6am, 4:15am, 6:25am, 6:30am, 12:10am. B. Review of fire drill reports for House 2 on 9/7/21 revealed the following: Five fire drills were conducted on third shift: 12am, 12am, 6:20am, 6:35am and 12am. During an interview on 9/8/21 the house supervisor agreed the fire drills were not conducted at varied times during third shift. He confirmed third shift hours are from 11:30pm to 7:30 am.	W 441	W441 In the future, evacuation drills will be conducted under varied circumstances and varied times on each shift. Specifically, fire drills will be conducted during varied times on 3rd shift. The Director will monitor fire drills once monthly to assure they are conducted during varied times on each shift.	11-8-201

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W 441	Continued From page 10 During an interview on 9/8/21 the qualified intellectual disabilities professional (QIDP) revealed the fire drills were not conducted during varied times. The QIDP stated third shift hours are from 11:30pm until 7:30am.	W 441		
W 484	DINING AREAS AND SERVICE CFR(s): 483.480(d)(3) The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 5 audit clients (#3) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plans (IPP) in the areas of dining. The finding is: During meal observations in the home and day program on 9/7 - 8/21, client #3 was not provided with his brightly colored utensils while he was eating. Further observations revealed there were no brightly colored utensils in any of the drawers in the kitchen of the home. Review on 9/7/21 of client #3's IPP dated 9/17/20 stated one of his adaptive equipment is brightly colored utensils. During an interview on 9/8/21, the home supervisor (HS) stated he has been working in the home for five years and had never seen client #3 use any brightly colored utensils. The HS	W 484	W484 Client # 3 will be provided with brightly colored dining utensils as identified in the PCP. All staff will be trained on the use of the specified utensils for client # 3. All staff will be trained on dining equipment needs for all clients. The Director or PC will monitor dining programs three times weekly. The RQP will monitor dining programs twice monthly. The Executive Director (Corporate Office) will monitor dining programs once monthly. All monitoring will be documented. Any concerns will be followed up on	11-8-2021

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W 484	Continued From page 11 revealed, "If the IPP stated it, he should be using them." During an interview on 9/8/21, the qualified intellectual disabilites professional (QIDP) confirmed client #3 should be using brightly colored utensils.	W 484		