NND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING IDENTIFICATION NUMBER A BUILDING IDENTIFICATION NUMBER A BUILDING IDENTIFICATION NUMBER A BUILDING IDENTIFICATION NUMBER IDENTIFICATION NUMBER </th <th></th> <th></th> <th>& MEDICAID SERVICES</th> <th>1</th> <th></th> <th>OMB NC</th> <th>0. 0938-039</th>			& MEDICAID SERVICES	1		OMB NC	0. 0938-039
MAKE DE PROVIDER OR SUPPLIER UMAGE DE PROVIDER OR SUPPLIER STREET ADDRESS, GITY, STATE, ZIP CODE 103/32/22/2 CHADANOKE HOUSE TOTAL STREET ADDRESS, GITY, STATE, ZIP CODE 103/32/22/2 CHADANOKE HOUSE STREET ADDRESS, GITY, STATE, ZIP CODE 103/32/22/2 CHADANOKE HOUSE STREET ADDRESS, GITY, STATE, ZIP CODE 103/32/22/2 CHADANOKE HOUSE STREET ADDRESS, GITY, STATE, ZIP CODE 103/32/22/2 CHADANOKE HOUSE STREET ADDRESS, GITY, STATE, ZIP CODE 103/32/22/2 CHADANOKE HOUSE STREET ADDRESS, GITY, STATE, ZIP CODE 103/32/22/2 CHADANOKE HOUSE STREET ADDRESS, GITY, STATE, ZIP CODE 103/32/22/2 CHADANOKE HOUSE STREET ADDRESS, GITY, STATE, ZIP CODE 103/32/22/2 CHADANOKE HOUSE STREET ADDRESS, GITY, STATE, ZIP CODE 103/32/22/2 W 263 PROVIDER STANO FOR DISCONCE TRANOUT 100/200/200/200/200/200/200/200/200/200/	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
NAME OF PROVIDER OF SUPPLIER STREETADDRESS. GTY: STRE_IP CODE SCI-ROANOKE HOUSE STREETADDRESS. GTY: STRE_IP CORE SCI-ROANOKE HOUSE STREETADDRESS. GTY: STRE_IP CORE W 263 PROVIDER PLAN OF ORRECTION ECONORMETION OF DEFICIENCIES PROVIDER PLAN OF ORRECTION ECONORMETION OF DEFICIENCY OWNED CONSTREETADDRESS. GTY: STRE_IP CORE CONSTREETADDRESS. GTY: STREETADDRESS. GTY: S			34G275	B. WING		03	/23/2022
PREFIX IEACH DEFICENCY MUST BE PRECEDED BY FULL REQUARTORY OR US: DEMTIFYING INFORMATION) PREFIX TAG IEACH DEFICENCY Converting DEFICIENCY W 263 PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) W 263 5-23-202: W 263 The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or leagl quardian. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a restrictive Behavior Support Plan (BSP) was conducted with the written consent of both guardians. This affected of 4 audit clients (#11). The finding is: Review on 3/23/22 of client #11's undled BSP revealed objectives to reduce the frequency of behaviors to 3 or less a month, 8 out of 12 months. The targeted behaviors were self-injurious, inappropriate touching and aggression. Client #11 would receive Ativan, Lithium, Trazadone. Zyprexa, Keppra and Inderall to manage her behaviors. The consent for restrictive behavior form was signed by one of the guardians on 1/27/22. The second guardian id not have a signature on file with the consent. The ROP will monitor for BIP consents at least quarterly. The Executive Director will monitor at least quarterly. The Executive Director will monitor at least quarterly. The Executive Director will be dolumented. Any concerns will be doluwed up on. W 369 Ortic QOMINISTRATION CFR(s): 483.460(k)(2) W 369					103 & 105 CLEARFIELD DRIVE		
CFR(s): 483.440(f)(3)(ii) 5-23-202: The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. W263 5-23-202: This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a restrictive Behavior Support Plan (BSP) was conducted with the written consent of both guardians. This affected 1 of 4 audit clients (#11). The finding is: W18b e obtained. In the future, when the client has co guardians written consent is obtained by both guardians. Review on 3/23/22 of client #11's undated BSP revealed objectives to reduce the frequency of behaviors to 3 or less a month, 8 out of 12 months. The targeted behaviors were self-injurious, inappropriate touching and aggression. Client #11 would receive Ativan, Lithium, Trazadore, Zyprexa, Keppra and Inderall to manage her behaviors. The control of social behavior treatment plan for control of social behavior tore ment plan for control of social behavior form was signed by one of the guardians on 1/27/22. The second guardian did not have a signature on file with the consent. The ROP will monitor for BIP consents at least quarterly. Interview on 3/23/22 with the Director revealed that she only received a signed consent from one of the guardians. The other guardian was temporarily placed out of her horme and was not available to return the consent. W 369 W 389 DRUG ADMINISTRATION CFR(s): 483.460(k)(2) W 369 W 389 DRUG ADMINISTRATION CFR(s): 483.460(k)(2) W 369 <td>PREFIX</td> <td>(EACH DEFICIENCY</td> <td>MUST BE PRECEDED BY FULL</td> <td>PREFIX</td> <td>PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO</td> <td>LD BE</td> <td>COMPLETION</td>	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
(X6) DATE (X6) DATE	W 369	CFR(s): 483.440(f)(The committee sho are conducted only consent of the clien minor) or legal guar This STANDARD is Based on record re facility failed to ensu Support Plan (BSP) written consent of be of 4 audit clients (#1 Review on 3/23/22 of revealed objectives behaviors to 3 or less months. The targete self-injurious, inappr aggression. Client # Lithium, Trazadone, to manage her beha restrictive behavior to social behavior form guardians on 1/27/22 not have a signature Interview on 3/23/22 w developmental profe she searched for a c consent but was una DRUG ADMINISTRA CFR(s): 483.460(k)(2	3)(ii) uld insure that these programs with the written informed t, parents (if the client is a dian. a not met as evidenced by: view and interviews, the ure a restrictive Behavior was conducted with the oth guardians. This affected 1 1). The finding is: of client #11's undated BSP to reduce the frequency of as a month, 8 out of 12 ed behaviors were opriate touching and #11 would receive Ativan, Zyprexa, Keppra and Inderall viors. The consent for reatment plan for control of was signed by one of the 2. The second guardian did on file with the consent. with the Director revealed ed a signed consent from one e other guardian was ut of her home and was not e consent. with the qualified intellectual ssional (QIDP) revealed that opy of both guardians ble to place it. TION 2)	W 365	W263 Written informed consent for client #11, as well as any other client's restrictive beha will be obtained. In the future, when the client co guardians written consent will be obtained by both guar The Director will assure that informed written consent is obtained by both guardians for all clients that utilize restri- techniques as a part of their behavior intervention program The RQP will monitor for BIP at least quarterly. The Executive Director will m at least quarterly. All monitoring will be docume Any concerns will be followed	vior pla has dians. ctive n. consen onitor nted. up on. Health 22	n
	ORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	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.

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2022 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	B. WING		02	3/23/2022	
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	STREET ADDRESS, CITY, STATE, ZIP CO 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870 PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	DE RECTION SHOULD BE	(X5) COMPLETION DATE	
	The system for drug that all drugs, includ self-administered, a This STANDARD is Based on observati interviews, the facilit audit clients (#3) red medication. The find During morning med House 2 on 3/23/22 poured 30 ml of Lac cup for client #3. The over hand technique medicine into his more handle the cup, part leaving 2 big drops a floor. The rest of clien given to him and he med tech was not ob before starting medic client #5 and stepped the floor, commenting the sticky floor. An a revealed the med tech assistant (PA) on the him that client #3 acc Lactulose. Client #3 the home and was ad Interview on 3/23/22 that client #3 receive medication spilled. S anymore medication the nurse to return he tech informed the sur PA and was advised	a administration must assure ling those that are re administered without error. ont met as evidenced by: ons, record review and ty failed to ensure that 1 of 4 seived a full dose of ding is: dication observations in at 8:00am, the med tech tulose syrup into a medicine e med tech attempted a hand to assist client #3 pour the both. When client #3 tried to of the contents spilled, and 2 small drops on the ent #'3s medications were left the room when done. The oserved to contact the nurse cation administration with d in the spilled medication on g that she needed to mop dditional observation, ch called the physician e phone at 10:40am, to inform cidentally spilled some of his had already departed from t the vocational center. with the med tech revealed d 15 ml of Lactulose after the	W 3	 W369 All Medication Monitors w training from the RN Clini on the nursing policy regarmedication administration errors. Re training will sp procedures to follow when is spilled during administr Monitoring of Medication A to assure medication is adwithout error will occur. The Regional Nursing Dimonitor Medication Adminonce weekly. The Clinical Nursing Direct (Corporate Office) will mo Medication Administration All monitoring will be docut Any concerns will be follow 	vill receive ical Directo arding and medi becifically a n medicatio ration. Administra dministered ector will histration ctor nitor once mon imented.	cation iddress on tion d	

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

Event ID: EEZS11 Facility ID: 944940

CENTE	R5 FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
	34G275		B. WING			03/22/2022	
NAME OF PROVIDER OR SUPPLIER SCI-ROANOKE HOUSE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			03/23/2022 STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870 ID PROVIDER'S PLAN OF CORRECTION				
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	Interview on 3/23/22 that she was not aw Lactulose during me Director revealed th during administratio informed and give ir director should be ir not return the call in physician assistant s Interview on 3/23/22 disabilities professio the medication is sp administration, and r dosage would be co EVACUATION DRIL CFR(s): 483.470(i)(1 and under varied con This STANDARD is Based on document the facility failed to e conducted during va This potentially affec home (#1, #2, #3, #4 and #12). The finding Review on 3/22/22 or April 2021-February 3 were conducted at 5: 6:56am on third shift. conducted during dea 4:00am.	2 with the Director revealed rare that client #3 spilled the ed pass until 10:30am. The at if medication is spilled n, the nurse should be instructions on what to do. The informed and if the nurse does a timely manner, then the should be advised. with the qualified intellectual nal (QIDP) revealed that if illed during medication not replaced; then the partial insidered a medication error. LS) nditions to- not met as evidenced by: treview and staff interview, insure fire drills were rying times and conditions. ted all of the clients in the , #5, #6, #7, #8, #9, #10, #11	W 3	41	VV441 In the future, fire drills will be co at a variety of times on all shifts The Director will conduct fire d once monthly and assure that to vary by time on all shifts. The QM department will monitor once monthly to assure they are at a variety of times. Additionally the Executive Direct (Corporate Office) will monitor for to assure they are conducted at of times once quarterly. All monitoring will be documented Any concerns will be followed u	onduc s. he dr he dr or fire e con ctor ire dr t a va ed.	ills drills ducted

Facility ID: 944940

ULIVILI	TO TOT MEDIONICE	A MEDICAID SERVICES			OND NO	. 0930-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G275	B. WING		03	23/2022
	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE 103 & 105 CLEARFIELD DRIVE ROANOKE RAPIDS, NC 27870	1 00	23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 441	Continued From pa shift, especially dur	ige 3 ing deep sleeping hours.	W 441			
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: EEZS	511 Fac	ility ID: 944940	nuation shee	t Page 4 of 4