STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G036	A. BUILDING _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN OAKS ROAD-DURHAM	614 SEVEN OAKS ROAD DURHAM, NC 27704

(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 observations, record review and interviews, the facility failed to ensure privacy for 1 of 3 audit clients (#1) residing in the home. The finding is: During morning observations in the home on 7/25/23 at 6:12am, client #1 was observed laying on her bed with her pants pulled down around her ankles. Further observations revealed client #1's disposable brief was visible. Additional observations revealed another client came out of their bedroom, stopped in the doorway of client #1's bedroom, spoke with Staff A and Staff A spoke with the client. Further observations revealed client #1's bedroom door remained open during this time. During an interview on 7/25/23, Staff A stated client #1 should have been allowed privacy while in her bedroom. During an interview on 7/25/23, management staff revealed client #1 should have been given privacy while she was in her bedroom. During an interview on 7/25/23, the Qualified Intellectual Disabilities Professional (QIDP) client #1's door should have been closed for privacy.	W 130		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the	W 189		

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

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W 189	Continued From page 1	W 189		

employee to perform his or her duties effectively, efficiently, and competently.
This STANDARD is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure staff were sufficiently trained in the disposable of medications and ensuring medication is applied correctly. The findings are:

A. During morning medication administration in the home on 7/25/23 at 6:29am, a single pill for a client dropped on the floor. The medication technician picked up the pill and threw it away in the trash can. At no time was any paperwork filled out or a phone call made.

During an interview on 7/25/23, management staff stated staff should have documented the pill falling on the floor. Further interview revealed the pharmacy would be notified and they would send out a replacement pill.

During an interview on 7/25/23, the Qualified Intellectual Disabilities Professional (QIDP) stated staff have been trained in the disposing of medications. The QIDP also revealed staff should have called triage and the triage would have given the staff instructions on what to do.

B. During morning medication administration on 7/25/23 in the home at 6:32am, the medication technician squeezed out cream from two different tubes into small medication cups. Further observations revealed both of the creams where white in color. The medication technician told the client that one of the creams was for her knee and the other one was for the bottom of her feet. Further observations revealed the medication technician told the client "I hope you don't get this mixed up." The medication technician then

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W 189	Continued From page 2 handed both the medications cups to the client and instructed her to go to her bedroom and apply them. At no time did the medication technician go with the client to her bedroom to ensure the creams where applied to the correct area. During an interview on 7/25/23, management staff revealed the medication technician revealed should have went with the client to ensure the medications should have been applied to the correct body parts. During an interview on 7/25/23, the Qualified Intellectual Disabilities Professional (QIDP) stated the medications technician should have observed the client apply the creams to the correct area on her body.	W 189		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(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 observations and interviews, the facility failed to ensure medications remained locked except when being prepared for administration. The finding is: During medications observations in the home during the survey on 7/24 - 25/23, a small black refrigerator, located in the medication room held two breathing treatment medications for a client. Further observations revealed the refrigerator did not have any type of lock. Additional observations revealed the door remained open during the survey and clients were able to walk in	W 382		

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W 382	Continued From page 3 and out without supervision. During an interview on 7/25/23, management staff revealed all medications are suppose to be locked, when not in use. During an interview on 7/25/23, the Qualified Intellectual Disabilities Professional (QIDP) stated medications are to be locked at all times when not in use.	W 382		