STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G173	A. BUILDING _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-COASTAL HOUSE I AND II	1972 &1974 WEST LAKE SHORE DRIVE WILMINGTON, NC 28401

(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 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 2 of 4 audit clients (#3 and #12). The findings are: A. During afternoon observations in the home on 2/5/24 at 4:07pm, staff A was observed to attempt to take client #12's vital signs. Client #12 removed the blood pressure cuff before vital signs were completed. Staff A was then observed at 4:11pm administering Thorazine 175mcg to client #12. After medications were administered, staff A took client #12's vital signs. Record review 2/6/24 of client #12's physician's orders dated 9/7/23 revealed an order for "Thorazine 100mg. Take 1 tablet by mouth three times daily with three of the 25mg tablets for a total dose of 175mcg. Hold for blood pressure less than 90/60 or pulse less than 60." Interview on 2/6/24 with the facility nurse confirmed client #12 should have had his vital signs checked prior to administration of Thorazine. B. During morning observations in the home on 2/6/24 at 8:20am, staff C was observed administering Levothyroxin 75mcg to client #3. Record review on 2/6/24 of client #3's physician's orders dated 9/7/23 revealed an order for	W 368		

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
	34G173	A. BUILDING _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-COASTAL HOUSE I AND II	1972 &1974 WEST LAKE SHORE DRIVE WILMINGTON, NC 28401

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W 368	Continued From page 1 "Levothyroxin 75mcg. Take one tablet every morning at 7:00am. Interview on 2/6/24 with the facility nurse revealed medications can be administered one hour before or one hour after the time it is ordered. The facility nurse confirmed client #3 received Levothyroxin outside of the time frame that is allowed.	W 368		
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 interview, the facility failed to ensure all medications remained locked except when being administered. The findings are: During observations in the home on 2/5/24 staff A was administering medications. At 4:12pm, staff A walked away from the medication cart to obtain vital signs leaving the cart unlocked. Further observations in the home on 2/5/24 at 4:25pm, staff A left the medication cart to return water and juice to the kitchen. The medication cart was left unlocked in the dining room. Interview on 2/6/24 with the facility nurse revealed the medication cart should always be locked unless staff are standing right beside it administering medications. The facility nurse confirmed the cart should be locked anytime staff walk away from it.	W 382		