STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G215	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-TRIANGLE HOUSE I	1406 TYONEK DRIVE DURHAM, NC 27703

(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 000	INITIAL COMMENTS A complaint survey was completed on 6/8/23 for intake #NC00202434. The complaint was substantiated. Deficiencies were cited related to the allegations.	W 000		
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 record review and confirmed by interviews with staff, the facility failed to ensure 1 of 6 clients (#6) received medications as prescribed. The finding is: Review on 6/8/23 of client #6's medication error report dated 5/8/23 revealed client #6 did not received his prescribed eye drops Dorzolamide Hydrochloride 2% to be administered at 8am and at 8pm to his affected eye on 5/7/23. Further review of the medication error report indicated that the container for the eye drops had not been opened. Additional review of this report indicated that the facility Nurse and the primary care physician had been notified. However, there was no follow up noted by the qualified intellectual disabilities professional (QIDP) or the facility Nurse. Interview on 6/8/23 with staff A confirmed she did not send the medication error report for client #6 to the facility Nurse or the QIDP. Record review on 6/8/23 of the facility's medication error policy which was revised in 2022, revealed once a medication error report	W 368	W 368 W 375 All staff will receive re training on Skill Creations policy on Medication Errors. Training will also be conducted with the Regional Nursing Director as well as Facility Administration on the Medication error policy. Reporting, Communication, Documentation and processing of reports will be highlighted. The “Buddy System” which has an assigned staff to review the MAR after each med pass will be re-implemented. The RN Clinical Director will monitor medication administration and medication error processing at SCI Triangle House 1 and 2 monthly. All monitoring will be documented.	8-7-2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Leslie Roughton
TITLE: Chief Operations Officer
(X6) DATE: 6-15-2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G215	A. BUILDING _____ B. WING _____	C 06/08/2023

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W 368	Continued From page 1 has been completed, this report should be forwarded to the clinical supervisor (QIDP) and the Facility Nurse who will follow up with the primary care physician and a determination will be made if direct care staff need additional training. The Regional QIDP is also to review for any necessary follow up. Interview on 6/8/23 with the QIDP and Regional QIDP confirmed this medication was not given as ordered by the physician and staff did not follow the facility's policy to ensure this medication error report for client #6 was forwarded to the QIDP and facility Nurse for necessary follow up. In addition, the regional QIDP stated the facility is to follow a buddy system for having a second staff check behind the medication technician for every shift. The regional QIDP stated this was not done per policy on 5/7/23.	W 368		
W 375	. DRUG ADMINISTRATION CFR(s): 483.460(k)(8) The system for drug administration must assure that drug administration errors and adverse drug reactions are recorded. This STANDARD is not met as evidenced by: Based on record review and interview, the system for medication administration failed to ensure complete and accurate recording was available for a medication errors for 1 of 6 clients (#6). The finding is: Review on 6/8/23 of client #6's medication error report dated 5/8/23 revealed client #6 did not received his prescribed eye drops Dorzolamide Hydrochloride 2% which is to be administered at	W 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 375	Continued From page 2	W 375		

8am and at 8pm to his affected eye on 5/7/23. Further review of the medication error report indicated that the container for the eye drops had not been opened. Additional review of this report indicated that the facility Nurse and the primary care physician (PCP) had been notified. However, there was no follow up noted by the qualified intellectual disabilities professional (QIDP) or the facility Nurse.

Interview on 6/8/23 with staff A confirmed she did not send the medication error report for client #6 to the facility Nurse or the QIDP.

Review on 6/8/23 of the facility's medication error policy revised in 2022 revealed once a medication error report has been completed, this report should be forwarded to the clinical supervisor (QIDP) and the Facility Nurse for further action.

Interview on 6/8/23 with the Regional QIDP revealed the facility's medication administration system was supposed to include notification to the QIDP, Facility Nurse, PCP and Pharmacist so trends and patterns of medication administration errors could be tracked. Additional interview revealed the facility's medication administration system was set up to identify if staff needed additional training and if there were problems with re ordering medications. The Regional QIDP identified that in May 2023 the facility had set up a buddy system where another staff checks behind the medication technician on each shift to minimize possible errors. The Regional QIDP acknowledged the buddy system had not used on 5/7/23 per company policy as evidenced by the delay noted in identifying this medication error on the medication error report.