STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G214	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-TRIANGLE HOUSE II	1523 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 #NC00202452. The complaint was substantiated. Deficiences 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 interview, the facility failed to ensure for 3 of 6 clients (#2, #3 and #6)'s medications were administered in accordance with physician's orders. The findings are: A. Review on 6/8/23 of client #2's medication error report dated 5/7/23 at 9am revealed when direct care staff A was checking medications on 5/8/23, she noted client #2 had not received Fosamax on 5/7/23. She notified the facility Nurse and the primary care physician (PCP) was notified. The report was signed by staff A, however there was no follow up recorded by the facility Nurse or the qualified intellectual disabilities professional (QIDP) or the regional QIDP. Interview on 6/8/23 with staff A confirmed she did not send the medication error report for client #2 to the facility Nurse or the QIDP. 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	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

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 368	Continued From page 1	W 368		

report for client #2 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.

B. Review on 6/8/23 of client #6's medication error report dated 5/7/23 revealed staff A was checking client #6's medications she discovered client #6's Fosamax had not been administered. Further review of this medication error report revealed there was no follow up by the facility Nurse or the QIDP. Further review revealed the facility Nurse contacted the PCP.

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.

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 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.

C, Review on 6/8/23 of client #3's medication error report dated 5/8/23 revealed on 6/8/23 staff A was checking client #3's medications she noted that her Fosamax had not been administered as prescribed on 5/7/23. Staff A recorded that she notified the facility Nurse and the PCP on 5/8/23.

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W 368	Continued From page 2 Further review of this medication error report revealed there was no follow up by the 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 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 staff A confirmed she did not send the medication error report for client #3 to the facility Nurse or the QIDP. Interview on 6/8/23 with the QIDP and regional QIDP confirmed this medication for clients #2, #3, #6 was not given as ordered by the physician and staff did not follow the facility's policy to ensure this medication error report 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	W 375		

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W 375	Continued From page 3	W 375		

system for medication administration failed to ensure complete and accurate recording was available for a medication errors for 3 of 6 clients (#2, #3 and #6). The findings are:

A. Review on 6/8/23 of client #2's medication error report dated 5/7/23 at 9am revealed when direct care staff A was checking medications on 5/8/23, she noted client #2 had not received Fosamax on 5/7/23. She notified the facility Nurse and the primary care physician (PCP) was notified. The report was signed by staff A, however there was no follow up recorded by the facility Nurse or the qualified intellectual disabilities professional (QIDP) or the regional QIDP.

B. Review on 6/8/23 of client #6's medication error report dated 5/7/23 revealed staff A was checking client #6's medications she discovered client #6's Fosamax had not been administered. Further review of this medication error report revealed there was no follow up by the facility Nurse or the QIDP. Further review revealed the facility Nurse contacted the PCP.

C, Review on 6/8/23 of client #3's medication error report dated 5/8/23 revealed on 6/8/23 staff A was checking client #3's medications she noted that her Fosamax had not been administered as prescribed on 5/7/23. Staff A recorded that she notified the facility Nurse and the PCP on 5/8/23. Further review of this medication error report revealed there was no follow up by the Nurse or the QIDP.

Interview on 6/8/23 with staff A confirmed she did not send the medication error reports for clients #2, #3 and #6 to the facility Nurse or the QIDP.

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W 375	Continued From page 4 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 these medication errors on the medication error reports.	W 375		