


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2024
NAME OF PROVIDER OR SUPPLIER SCI-COASTAL HOUSE I AND II		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
W 368	<p>DRUG ADMINISTRATION CFR(s): 483.460(k)(1)</p> <p>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:</p> <p>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.</p> <p>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."</p> <p>Interview on 2/6/24 with the facility nurse confirmed client #12 should have had his vital signs checked prior to administration of Thorazine.</p> <p>B. During morning observations in the home on 2/6/24 at 8:20am, staff C was observed administering Levothyroxin 75mcg to client #3.</p> <p>Record review on 2/6/24 of client #3's physician's orders dated 9/7/23 revealed an order for</p>	W 368	<p>W368 In the future all clients will receive medication as ordered by the physician. All staff will receive training on policy 11004B Medication Administration.</p> <p>The Regional Nursing Director will monitor medication administration once per week to assure that all clients receive medication as prescribed without error.</p> <p>All monitoring will be documented. Any concerns will be followed up on as needed.</p> <p style="text-align: center;">RECEIVED FEB 15 2024 DHSR-MH Licensure Sect</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 		TITLE Chief Operations Officer	(X6) DATE 2/9/2024

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 "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	W382 All drugs and biologicals will be stored / locked except when being prepared for administration. All staff will receive training in policy 11004-A regarding Medication storage. Training will specifically address securing the medication cart when not administering medications. The Regional Nursing Director will monitor medication storage once per week to assure that medication are locked except when being prepared for administration. All monitoring will be documented. Any concerns will be followed up on as needed.	4-6-2024