

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER SCI-TRIANGLE HOUSE I			STREET ADDRESS, CITY, STATE, ZIP CODE 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 227	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the individual program plan (IPP) identified specific objectives to meet client #5's needs. This affected 1 of 4 audit clients. The finding is:</p> <p>The facility did not ensure client #5's IPP included objectives to tolerate the hand protector.</p> <p>Evening observations in the group home on 9/9/24, client #5 was walking with his hands holding onto his walker without wearing his palm protectors on each hand. Client #5 then went outside to participate in an activity without wearing his palm protectors. Further observation on 9/10/24 client #5 did not wear his palm protectors when he was walking to the breakfast table. Client #5 was not wearing palm protectors when leaving to attend the day program.</p> <p>Review on 9/9/24 of occupational therapy assessment dated 11/9/23 revealed recommendation of wearing palm protectors that would protect the palm from skin breakdown and should worn for extended amount of time.</p> <p>Interview on 9/10/24 staff C revealed that client #5 should wear his palm protectors but he doesn't like wearing them. Client #5 does have skin breakdown in his hands sometimes.</p> <p>Interview on 9/10/24 the qualified intellectual</p>	W 227			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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

PRINTED: 09/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER SCI-TRIANGLE HOUSE I			STREET ADDRESS, CITY, STATE, ZIP CODE 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 227	Continued From page 1 disabilities professional (QIDP) confirmed client #5 should wear his palm protectors and be offered his palm protectors daily.	W 227			
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a nourishing, well balanced diet including modified specially prescribed diet as prescribed. This affected 1 of 4 audit clients (#4). The findings is: Dinner observation in the home on 9/9/24, client #4 meal consisted of tomato soup, turkey burger and fruit. Review on 9/10/24 of client #4's Individual Program Plan (IPP) dated 3/4/24 stated he is allergic to tomato. Review on 9/10/24 of client #4's physician orders signed 7/31/24 stated he is allergic to tomato. Interview on 9/11/24, staff C stated he was not aware of any known food allergies for client #4. Interview on 9/11/24, the Home Manager confirmed client #4 was allergic to tomatoes.He would have some intestinal issues if consumed.	W 460			