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 _____	09/09/2025

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 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of objective implementation, medication administration and adaptive equipment use. This affected 3 of 4 audit clients (#1, #3 and #4). The findings are: A. During morning observations of medication administration in the home on 9/9/25 at 7:08am, client #4 participated with the administration of his medications by coming to medication area, ingesting his pills, including Propanolol, throwing away his trash and taking his cup to the kitchen. The Medication Technician (MT) completed all other tasks. Interview on 9/9/25 with the MT indicated client #4 does not have any specific tasks or goals related to the administration of his medications. Review on 9/9/25 of client #4's Individual Program Plan (IPP) dated 2/3/25 revealed he	W 249		

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.

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 _____	09/09/2025

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 249	Continued From page 1	W 249		

reports to the medication area, disposes of his cup and requires hand over hand assistance to pour his liquids. The IPP notes he independence is promoted during medication administration. Additional review of the client's Nursing Care Plan (NCP) identified a goal to maintain his current skill level with his medication administration over the next year. Further review of the goal noted client #4 will come to the medication area when notified, assist with sanitizing his hands, dispose of trash and staff will work with him on learning his new medication name and what it treats (Propanolol: Blood pressure).

Interview on 9/9/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 should participate with the administration of his medications as indicated in the NCP and IPP.

B. During observations at the day program on 9/8/25 11:52am, Staff A set up client #4's dining items prior to the client entering the dining area.

Review on 9/8/25 of client #4's IPP dated 2/3/25 revealed an objective to place his utensils in appropriate spot for lunch with prompts for 6 sessions for 1 month over 6 consecutive months (implemented 12/6/24).

Interview on 9/9/25 with Staff A revealed no clients have any specific objectives they work on during meals at the day program.

Interview on 9/9/25 with the Director confirmed client #4's objective should have been implemented at the lunch meal.

C. During lunch observations at the day program on 9/8/25 at 11:52am, all clients consumed their

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 _____	09/09/2025

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 249	Continued From page 2 meals utilizing a high-sided sectioned plate. Interview on 9/9/25 with Staff A revealed client #1 and client #3 do not require any specific adaptive dining equipment at meals; however, client #4 uses a scoop plate. Review on 9/8/25 of client #1 and client #3's IPP dated 7/14/25 and 4/14/25, respectively, revealed no adaptive dining equipment is required at meals. Additional review of client #4's IPP dated 2/3/25 noted he requires a scoop plate to consume his meals. Interview on 9/9/25 with the Director confirmed client #1 and client #3 do not require adaptive dining equipment at meals while client #4 should use a scoop plate.	W 249		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #3's Individual Program Plan (IPP) was revised as necessary after he successfully completed an objective. This affected 1 of 4 audit clients. The finding is: Review on 9/8/25 of client #3's Behavior Support Plan (BSP) dated 3/19/25 revealed an objective to display 0 target behaviors per month for 8 out of 12 consecutive months. Target behaviors for	W 255		

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 _____	09/09/2025

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 255	Continued From page 3 the BSP include inappropriate toileting, inappropriate sexual behavior and property destruction. Additional review of the plan also noted the use of Paxil 10mg (behaviors) and Keppra 1000mg (seizures). Further review of progress notes for the objective over the past 20 months (December 2023 - August 2025) revealed one target behavior (inappropriate toileting) had been exhibited by client #3. Interview on 9/9/25 with the Qualified Intellectual Disabilities Professional (QIDP) indicated she was not aware of any revisions to the IPP based on client #3's apparent completion of his behavior objective.	W 255		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client #3 was considered for a reduction and/or elimination of drugs used to control behaviors after a significant decrease in the his behaviors was identified. This affected 1 of 4 audit clients. The finding is: Review on 9/8/25 of client #3's Behavior Support Plan (BSP) dated 3/19/25 revealed an objective to display 0 target behaviors per month for 8 out of 12 consecutive months. Target behaviors for the BSP include inappropriate toileting, inappropriate sexual behavior and property destruction. Additional review of the plan also	W 312		

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 _____	09/09/2025

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 312	Continued From page 4 noted the use of Paxil 10mg (behaviors) and Keppra 1000mg (seizures). Further review of progress notes for the objective over the past 20 months (December 2023 - August 2025) revealed one target behavior (inappropriate toileting) had been exhibited by client #3. The progress notes also indicated no changes had been considered for the client's behavior medication over the past 20 months after a significant decrease in his behaviors was identified. Interview on 9/9/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the interdisciplinary team had not considered a reduction and/or elimination of client #3's behavior medications based on his decrease in behaviors.	W 312		
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, record reviews and interviews, the facility failed to ensure all drugs remained locked except when being administered. The finding is: During morning observations of medication administration in the home on 9/9/25 from 7:24am - 7:48am, the Medication Technician (MT) left the medication cart unlocked and unattended on five separate occasions while out of the area assisting various clients. Interview on 9/9/25 with the MT revealed she had not been trained to keep medications secure	W 382		

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 _____	09/09/2025

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 382	Continued From page 5 before leaving the area while in the process of administering them. Review on 9/9/25 of the facility's Medication Labeling, Storage, and Disposal policy (revised 2024 - 0815) revealed, "The medication storage area remains locked at all times unless in use." Interview on 9/9/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed all medication technicians are trained to secure drugs properly.	W 382		
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure problems/difficulties with evacuation drills were investigated. This potentially affected all client residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 9/8/25 of facility fire drill reports revealed the following: 3/20/24 - "Have a client who is dependable assist with a wheelchair." 11/3/24 - "Use clients that are able to push the wheelchairs safely in assisting with exiting the building." 5/7/25 - "Staff followed directions provided in allowing a client to push one of the wheelchairs while staff push the other two wheelchairs and had clients with them."	W 448		

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 _____	09/09/2025

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 448	Continued From page 6 8/28/25 - "[Client #1] was assisting staff with wheelchairs due to only 2 staff and 3 wheelchairs. He assisted with [Client #5] and as they were going down the ramp [Client #1's] pants was falling down and assisted the wheelchair with 1 hand while pulling his pants made client [Client #5's] chair swirve and when stopped he fell out onto his knees, causing 2 scratches, also was not buckled in the wheelchair." Interview on 9/9/25 with Staff D revealed he works third shift and client #1 and client #3 usually assist staff during fire drills by pushing wheelchairs outside of the home. Interview on 9/9/25 with the Director indicated at least three clients (#1, #3 and #6) assist staff with fire drills by pushing a wheelchair. The Director noted this was done due to only two staff working a shift and three clients in wheelchairs in need of assistance during fire drills. Additional interview with the Director revealed she did not know clients could not assist staff with other clients during fire drills. Further interview did not indicate the facility's management staff had investigated incidents in which clients assisted with fire drills to develop a plan to ensure problems or difficulties were resolved.	W 448		