| 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 _____ | 09/03/2025 |

| 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 |
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| W 130 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(7)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.<br>This STANDARD is not met as evidenced by:<br>Based on observation and interviews, the facility failed to ensure clients were afforded privacy. This affected 2 of 6 audit clients (#1 and #3) . The findings are:<br><br>A. During evening medication administration observations on 9/2/25 at 7:05pm, Staff B was observed to give client #1 a pill and two brands of eye drops in the foyer area of the home while clients #2, #3 and #6 were in the vicinity. The Director was able to redirect client #2 to another area, however client #3 sat on the sofa near the medication cart and client #6 walked in and out of the room, and would approach Staff B randomly.<br><br>B. During morning medication administration observations on 9/3/25 at 7:30am, Staff D was observed to give client #3 six pills and one topical ointment on her face, as client #1 sat on the sofa near the medication cart.<br><br>Interview on 9/2/25 with the Director revealed they do not use the medication closet because it was too small to store the mobile medication cart. The Director explained they give medication in the foyer area of the home because all medications must be administered in front of a video camera.<br><br>Interview on 9/3/25 with the Director of Nursing (DON) confirmed staff are instructed to give medications in an open area because the medication room is too small to store the | W 130 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| W 130 | Continued From page 1<br>medication cart. Each home has a designated area to administer the medication and this home uses the foyer area. The DON acknowledged that unless the client needed to have a cream or lotion applied in private area, it was okay to give medications in the foyer, since staff should assist with keeping the area cleared of other clients present. | W 130 | | |
| W 369 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(2)<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure medications were administered without error for 1 of 6 audit clients (#1). The findings is:<br><br>During evening medication administration observations on 9/2/25 at 7:07pm, Staff B applied one drop of Latanoprost Sol 0.005% into the left and right eye of client #1. Staff B prompted client #1 to count to 10 with her 4x before she removed a second container of eye drops Dorzol/Timol Sol 2-5% OP into each eye at 7:08pm.<br><br>Review on 9/3/25 of client #1's Physician's Order signed on 7/25/25 revealed Dorzol/Timol Sol 2-0.5% OP should have one drop instilled into each eye and Latanoprost Sol 0.005% should have one drop instilled into each eye at bedtime.<br><br>Interview on 9/3/25 with the Regional Qualified Intellectual Developmental Professional (RQIDP) revealed there were no formal instructions for how to dispense eye drops but it would have part | W 369 | | |

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| W 369 | Continued From page 2<br>of the training on the medication administration checklist that medication technicians would have received.<br><br>Interview on 9/3/25 with the Director of Nursing (DON) revealed medication technicians are trained to wait 3 to 5 minutes after giving the first brand of eye drops before administering the second brand of drops. The DON confirmed that only waiting 40 seconds between the brand of eye drops were too soon because the second drops can wash out the first drops if given in less time. | W 369 | | |
| W 454 | INFECTION CONTROL<br>CFR(s): 483.470(l)(1)<br><br>The facility must provide a sanitary environment to avoid sources and transmission of infections.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, policy review and interview, the facility failed to ensure that staff remove contaminated gloves before beginning a new task. This affected 4 of 6 audit clients (#1, #2, #3 and #4). The findings are:<br><br>A. During observations in the home on 9/2/25 at 6:05pm, Staff B wore disposable gloves while assisting client #2 pull her chair up to the table. Staff B continued wearing the same gloves when helping clients #1, #2 and #3 set up their plates, cutting up foods with a Rocker knife and helping to pass bowls. Once the trays were set up, Staff B sat down at the table between client #1 and #3 and continued to assist them while they ate their tacos and beans.<br><br>B. During observations in the home on 9/2/25 at | W 454 | | |

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| W 454 | Continued From page 3<br>6:05pm, Staff C wore disposable gloves while transferring food from serving bowls to client #4's plate and then proceeding to feed her.<br><br>Review on 9/3/25 of the facility's Standard Precaution Principles for Infection Control dated 8/14/23 revealed staff shall replace gloves as soon as practical when contaminated. Gloves shall be changed between clients.<br><br>Interview on 9/3/25 with the Director of Nursing (DON) revealed she did not know of any purpose of wearing disposable gloves during meal activities unless protecting an open area. The DON also emphasized gloves should be changed between clients. | W 454 | | |
| W 460 | FOOD AND NUTRITION SERVICES<br>CFR(s): 483.480(a)(1)<br><br>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure that clients received prescribed modified diets according to physician's orders. This affected 3 of 6 audit clients (#1, #3 and #5). The finding are:<br><br>A. During meal observations in the home on 9/2/25 at 6:00pm, client #1 was served 2 whole soft tortillas, double portions of chopped grilled chicken, shredded cheese, diced tomatoes, shredded lettuce and baked beans for dinner. Staff B assisted client #1 to load her taco by having her placed the meat and vegetables inside | W 460 | | |

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| W 460 | Continued From page 4 | W 460 | | |

of the taco and fold it to eat. Client #1 consumed all of her food.

Review on 9/3/25 of client #1's individual program plan (IPP) dated 5/12/25 revealed a diet order of a heart healthy chopped reduced 1200 calories diet. No rolls or carrots and limit bread to 1 serving per the guardian. An additional review of the menu on 9/2/25 revealed the serving size for chicken is 2 ounces, a half cup of beans and one serving of tortilla for a 1200 calories diet.

B. During meal observations in the home on 9/2/25 at 6:00pm, client #3 was served 2 whole soft tortillas, double portions of chopped grilled chicken, shredded cheesed, diced tomatoes, shredded lettuce and baked beans for dinner. An additional observation on 9/3/25 at breakfast at 8:30am revealed client #3 ate two whole waffles and double portions of scrambled eggs. Client #3 consumed all of her food.

Review on 9/3/25 of client #3's IPP dated 6/23/25 revealed a diet order of a heart healthy reduced 1500 calories diet. Client #3 should not receive extra portions. An additional review of the menu for 9/2/25 revealed the serving size for chicken is 2 ounces, a half cup of beans and one serving of tortilla for a 1500 calories diet. An additional review of monthly weights for client #3 revealed a 5 lbs. weight gain between March 2025 to August 2025.

C. During meal observations in the home on 9/2/25 at 6:00pm, client #5 was served 2 whole soft tortillas, double portions of chopped grilled chicken, baked beans, shredded cheese, diced tomatoes and shredded lettuce for dinner. An additional observation on 9/3/25 at 8:30am

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| W 460 | Continued From page 5<br>revealed client #5 being served 2 waffles, double portions of scrambled eggs and chopped cantaloupe. Client #5 consumed all of her food.<br><br>Review on 9/3/25 of client #5's IPP dated 8/11/25 revealed a diet order of 1200 calories with double portions of only protein. An additional record review of the menu for 9/2/25 dinner revealed the serving size of chicken is 2 ounces, a half of cup of beans and one serving of tortilla for a 1200 calories diet. The menu for 9/3/25 at breakfast revealed the serving size of half cup of fruit, 1 waffle and 1 egg for a 1200 calories diet. An additional review of client #5's monthly weights revealed a 5 lbs. weight gain between March 2025 to August 2025.<br><br>Interview on 9/3/25 with the Director confirmed staff were not using measured utensils to maintain portions for calories reduced diets.<br><br>Interview on 9/3/25 with the Regional Qualified Intellectual Disabilities Professional (RQIDP) confirmed that the diet orders posted in the kitchen and IPP were accurate and that clients #3 and #5 did have weight gain this year. | W 460 | | |