STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G065	A. BUILDING _____ B. WING _____	01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTLEIGH	3300 HUNTLEIGH DRIVE RALEIGH, NC 27604

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W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, policy review and interviews, the facility failed to ensure staff were sufficiently trained regarding the disposer of medications. The finding is: Staff were not sufficiently trained regarding the disposal of medications. During medication observations in the home on 1/14/19 at 4:21pm, a pill landed on the floor while the client was punching his bubble pack. The medication technician picked up the pill and put it in the trash can. Further observations revealed the medication technician taking the trash bag with the pill still inside and placing it in the trash can which is located outside. During an interview on 1/14/19, the medication technician stated the pill will remain in the trash can and he will take it out and put it in the trash can which is located outside. Review on 1/15/19 of the facility's medication disposal policy (no date) revealed, "All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion of accidental ingestion. During an interview on 1/14/19, the home manager (HM) reported when a pill lands on the	W 189		

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

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W 189	Continued From page 1 floor the nurse is to be called. Further interview revealed the nurse will inform the staff to use the Drug Buster; which dissolves the pill and then a medication disposal form is filled out, signed/dated and reviewed.	W 189		
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 observation, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of self help skills and medication administration. This affected 3 of 5 audit clients (#4, #5, #6). The findings are: 1. Clients #4 and #5 were not prompted to use a napkin during meals. a. During dinner observations in the home on 1/14/19, client #4 was observed wiping his mouth on the sleeve of his shirt on two separate occasions. When client #4 was finished with dinner and stood up he had particles of food on his chin/mouth area. At no time was client #4	W 249		

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W 249	Continued From page 2	W 249		

prompted to wipe his mouth. Further observations revealed client #4 had napkins at his place setting.

Review on 1/15/19 of client #4's community/home life assessment dated 12/2/18 revealed he needs verbal cues to wipe his mouth while he is eating.

b. During breakfast observations in the home on 1/15/19, client #5 was not prompted to use a napkin while he was eating. Further observations revealed when client #5 left the dining room he had several pieces of oatmeal on his chin/mouth area. Additional observations revealed there were no napkins were placed on the table until after client #5 had left the dining room.

Review on 1/15/19 of client #5's community/home life assessment dated 9/13/17 revealed he needs verbal cues to wipe his mouth while he is eating.

During an interview on 1/15/19, the home manager (HM) confirmed clients #4 and #5 should have been prompted to wipe their mouths while they were eating.

2. Client #6 was not given the opportunity to fully participate in medication administration to the best of his ability.

During medication administration on 1/14/19, the medication technician spoon feed client #6 his medications. At no time was client #6 given the opportunity to feed himself. During observations in the home and day program, client #6 was observed feeding himself without any assistance from staff.

During an interview on 1/14/19, the medication

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W 249	Continued From page 3 technician revealed he spoon fed client #6 his medications because he wanted to make sure he "got all of the meds." The medication technician stated, "Nobody told me to do that; it's my method." Review on 1/15/19 client #6's community/home life assessment dated 12/7/18 revealed he is independent in using a spoon to fed himself. During an interview on 1/14/19, the home manager (HM) confirmed client #6 should have fed himself his own medications.	W 249		
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 interviews, the facility failed to ensure all medications remained locked. The finding is: The medications were left unsecured and unsupervised. During medication administration observations in the home on 1/14/19 at 4:14pm, the medication technician exited the medication area to obtain a chair for a client. Further observations revealed while the medication technician left the area, a container which contained medication bubble packs of pills was left out on the desk. Additional observations revealed the surveyor was left alone with the medications in full view.	W 382		

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W 382	Continued From page 4 During an interview on 1/14/19, the medication technician stated, "I Knew not to leave the medications unattended, it was an oversight." Further interview revealed the medication technician had been trained not to leave medication unattended. Review on 1/14/19 of medication administration procedures (no date) revealed, "At no point in time during administration should medications be left unattended!" During an interview on 1/14/19, the home manager (HM) confirmed at no time are medications left out unattended.	W 382		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure only authorized persons have access to keys to the drug storage area. The finding is: Keys to the facility's drug storage area were accessible to anyone in the home. During medications observations in the home on 1/14/19 at 4:18pm, the medication technician left the medication area to ask the home manager (HM) a question. Further observations revealed the keys to the medication closet was left out on the table. Additional observations revealed the	W 383		

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W 383	Continued From page 5 keys were visible to the surveyor. During an immediate interview, the medication technician confirmed the keys to the medication closet were left unattended. Further interview they had training not to leave the keys to the medication unattended. During an interview on 1/14/19, the HM confirmed the keys to the medication closet should be kept on the person of the assigned medication technician. During an interview on 1/15/19, the qualified intellectual disabilities professional (QIDP) revealed the home had been cited for this citation in the past and they came up with an elastic band, so staff can keep they keys on their wrist.	W 383		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the infections control prevention procedures were carried out. The finding is: Precautions were not taken to promote client health and prevent possible cross-contamination. During breakfast observations in the home on 1/15/19, staff used the same rocker knife to cut the toast and sausage patties of two different	W 455		

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W 455	Continued From page 6 clients. Further observations revealed one of the clients had already taken one bite out of his toast before it was cut. At no time was the rocker knife washed between clients. During an interview on 1/15/19, the staff revealed the rocker knives are always cleaned between clients. During an interview on 1/15/19, the home manager (HM) stated, "I have never thought about how the rocker knives would need to be cleaned between clients."	W 455		