

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

PRINTED: 07/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2019
NAME OF PROVIDER OR SUPPLIER HUNTLEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 HUNTLEIGH DRIVE RALEIGH, NC 27604		
(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 000	INITIAL COMMENTS	W 000			
W 130	<p>No deficiencies were cited as a result of a complaint survey conducted on 7/11/19 for Intake #NC00152375. The allegation was unsubstantiated. However four standard level deficiencies were cited.</p> <p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure privacy for 1 of 2 clients (#5) residing in the home. The finding is:</p> <p>Client #5 was not afforded privacy while using the bathroom.</p> <p>During morning observations in the home on 7/11/19 at 7:34am, the client #5 was observed sitting on the toilet while Staff C was standing in the bathroom with him, with the door wide open. At 7:36am, Staff C was observed assisting client #5 with personal care. At no time was the door closed.</p> <p>During an interview on 7/11/19, Staff C revealed the bathroom door should have been closed to give client #5 privacy. Further interview revealed Staff C had training on ensuring the privacy for the clients in the home.</p> <p>Review on 7/11/19 of client #5's community/home</p>	W 130			

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: 07/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2019
NAME OF PROVIDER OR SUPPLIER HUNTLEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 HUNTLEIGH DRIVE RALEIGH, NC 27604		
(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 130	Continued From page 1 life assessment dated 9/13/17 revealed he is independent in observing privacy.	W 130			
W 249	<p>During an interview on 7/11/19, the home manager (HM) reported "normally [Client #5] will slam the bathroom door closed."</p> <p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 2 audit clients (#3, #5) received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas appearance and fall prevention guidelines. The findings are:</p> <p>1. Client #3 was not afforded the opportunity to have clean dry clothing.</p> <p>During morning observations in the home on 7/11/19 from 6:58 until 7:49am, client #3's pants were visibly wet from the waist down to right above his left knee. Further observations revealed client #3 walking around the home, staff coming up and talking with him face to face and</p>	W 249			

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

PRINTED: 07/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2019
NAME OF PROVIDER OR SUPPLIER HUNTLEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 HUNTLEIGH DRIVE RALEIGH, NC 27604		
(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	<p>Continued From page 2 one staff giving him a hug while facing him.</p> <p>Review on 7/11/19 of client #3's IPP dated 10/25/18 revealed, "Inappropriate Toileting: Urinating on self. Person Responsible: Staff...."</p> <p>During an interview on 7/11/19, the home manager (HM) revealed client #3 will point to his private area when he is wet. Further interview revealed client #3 will use the universal sign to indicate he needs to use the bathroom.</p> <p>2. Client #5's clothing did not fit properly.</p> <p>During observations in the home on 7/11/19 at 7am; 7:09am; 7:17am and 7:21am, client #5's pants slid down past his waist whenever he stood up to walk. Further observations revealed his undergarments were visible to anyone in the home. Additional observations revealed staff just pulling up his pants and not assisting client #5 with changing his pants.</p> <p>Review on 7/11/19 pf client #5's community/life assessment dated 9/13/17 revealed he needs verbal cues from staff to adjust his clothing and to check his appearance.</p> <p>During an interview on 7/11/19, the HM revealed staff should have ensured his pants were fitting properly.</p> <p>3. Client #3's fall prevention guidelines where not followed.</p> <p>During observations in the home on 7/11/19 at 7am; 7:09am; 7:17am and 7:21am, client #5 was observed walking on his own. Further observations revealed he was not wearing his gait</p>	W 249			

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

PRINTED: 07/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2019
NAME OF PROVIDER OR SUPPLIER HUNTLEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 HUNTLEIGH DRIVE RALEIGH, NC 27604		
(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 3 belt. At no time did staff ensure client #5's gait belt was being worn. During an interview on 7/11/19, Staff C revealed client #5's gait belt is suppose to be worn at all times while he is ambulating. Further interview revealed staff are to hold onto the gait belt while client #5 is ambulating. Review on 7/11/19 of client #5's IPP dated 9/28/19 revealed he uses the gait belt to prevent falls and it is used whenever he is ambulating. Review on 7/11/19 of client #5's fall prevention and safety guidelines dated 4/7/17 stated, "... [Client #5] is to wear gait belt when mobile, whether he requires assistance or not...." During an interview on 7/11/19, the HM revealed client #5 is suppose to have his gait belt on at all times whenever he is ambulating. Further interview revealed client #5 is a fall risk. The HM also reported staff have been trained to ensure client #5 gait belt is on at all times.	W 249			
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. This potentially affected one client residing in the home. The finding is:	W 455			

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

PRINTED: 07/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2019
NAME OF PROVIDER OR SUPPLIER HUNTLEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 HUNTLEIGH DRIVE RALEIGH, NC 27604		
(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 455	Continued From page 4 Precautions were not taken to promote client health and prevent possible cross-contamination. During breakfast observations in the home on 7/11/19 client #5's container of Thick It milk fell to the floor while Staff B was pouring it. Further observations revealed Staff B picking it up and pouring the remainder into client #5's glass. During an immediate interview Staff B revealed client #5's Thick It milk did not spill out and it did not land on its' top, so it was OK to pour the remainder into client #5's glass. During an interview on 7/11/19, the home manager (HM) revealed the Thick It milk container should have been discarded and staff should have got a brand new one for client #5.	W 455			
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 continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the area of diet. This affected 1 of 2 audit clients (#5). The finding is: Client #5's diet consistency were not followed.	W 460			

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

PRINTED: 07/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2019
NAME OF PROVIDER OR SUPPLIER HUNTLEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 HUNTLEIGH DRIVE RALEIGH, NC 27604		
(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 460	<p>Continued From page 5</p> <p>During morning observations in the home on 7/11/19 at 7:48, client #5 drank out of a container of Ensure. Further observation revealed the Ensure was a thin consistency. Additional observations revealed client #5 did not cough while he was drinking the Ensure.</p> <p>During an immediate interview, Staff C confirmed client #5 only drinks liquids which are honey thick in consistency.</p> <p>Review on 7/11/19 of client #5 diet order dated 10/8/18 stated, "...Honey Thick Liquids."</p> <p>Review on 7/11/19 of client #5's monthly nursing notes for June 2019 revealed he drinks honey thick liquids.</p> <p>During an interview on 7/11/19, the home manager (HM) confirmed client #5 liquid consistency is honey thick and he should not have drank the thin consistency Ensure.</p>	W 460			