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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING ______ B. WING ______	07/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 assure interactions with staff supported the active treatment program specifically the medication administration guidelines of 1 of 4 audit clients (#3). The finding is: Client #3's medication guidelines were not consistently implemented as written. During the medication administration pass on 7/23/19 at 7am, client #3 came into the medication room, then staff A took his medication box out and set it on the desk. Client #3 then assisted with punching medications by independently holding the packets and pressing the pills out. Interview with Staff A on 7/23/19 after the observation, revealed client #3 can come in and punch his medications as far as she knows because "nobody has told me any different" and this allows him to be more independent at medication administration.	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.

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W 249	Continued From page 1 Review of client #3's IPP dated 12/7/18 revealed that he had medication administration guidelines from the previous year 12/7/17 which were still to be carried out. These guidelines indicated that the medication box for client #3 should be taken out and placed on the desk prior to him entering the room. The guidelines also noted that client #3 should "...at NO TIME have a blister pack with medications still in tact, in his hands (i.e [Client #3's] own medication pack and/or any other consumer's....)" Interview with management on 7/23/19 confirmed that client #3's medication administration guidelines are current and that he should not be allowed to hold medications and participate in medication punching due to previous behaviors of taking medications he should not take even with staff present.	W 249		