

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

PRINTED: 09/20/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>09/20/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>HUNTLEIGH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 HUNTLEIGH DRIVE</b> <b>RALEIGH, NC 27604</b>		
(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 418	<p>CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii)</p> <p>The facility must provide each client with a clean, comfortable mattress.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure client #2 had a comfortable mattress. This affected 1 of 6 clients residing in the home. The finding is:</p> <p>Client #2 was in need of a new mattress.</p> <p>During observations in the group home on 9/20/19, client #2's mattress was noted to have an indentation or dip on the side towards the wall. The mattress was cracked and faded in that area. Further observation revealed a strong ammonia odor coming from the client's room.</p> <p>Review of the client behavior support plan dated 12/1/18 revealed a target behavior, "...inappropriate toileting..."</p> <p>During an interview on 9/20/19, the home manager acknowledged the mattress had a noticeably dip or sink on the side towards the wall. She further added client #2 had a behavior of in appropriate toileting and he is on training program for toileting. Staff are prompting him to toilet every hour while awake and last thing before going to bed.</p> <p>During an interview on 9/20/19 with the acting</p>	W 418			

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: 09/20/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>09/20/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>HUNTLEIGH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 HUNTLEIGH DRIVE</b> <b>RALEIGH, NC 27604</b>		
(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 418	Continued From page 1 qualified intellectual disabilities professional (QIDP) confirmed the mattress had a dip in the middle.	W 418		