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 _____	R-C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTLEIGH	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 418	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii) The facility must provide each client with a clean, comfortable mattress. 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: Client #2 was in need of a new mattress. 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 matress was cracked and faded in that area. Further observation revealed a strong ammonia odor coming from the client's room. Review of the client behavior support plan dated 12/1/18 revealed a target behavior, "....inapproriate toileting..." 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. During an interview on 9/20/19 with the acting	W 418	This deficiency will be corrected by the following actions: A. The Home Manager and/or the Clinical Supervisor will contact maintenance to request that the mattress for client #2 is replaced in a timely manner. B. The Home Manager will complete a monthly assessment, form F2.32B Home Checklist, of the home and the items within it to ensure that any items that need replacement or repair are addressed. C. The Home Manager will ensure that any items that do need replacement or repair are addressed by the appropriate individuals. D. The Program Manager will monitor this monthly assessment checklist through documentation review which will occur at a minimum of 1x/month. DHSR-Mental Health SEP 2 6 2019 Lic. & Cert. Section	10/15/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Program Manager — (X6) DATE: 9/24/19

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.

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 _____	R-C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTLEIGH	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 418	Continued From page 1 qualified intellectual disabilities professional (QIDP) confirmed the mattress had a dip in the middle.	W 418		

DHSR-Mental Health
SEP 2 6 2019
Lic. & Cert. Section

September 24, 2019

Wambui Karanu, BSN, RN
Nurse Consultant I
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Plan of Correction for Follow-up Survey
Provider Number: 34G065
MHL Number: MHL-092-261

Dear Ms. Karanu,

Thank you for your time and the feedback given during the survey you completed on September 20, 2019. We appreciate your diligence in assisting us in providing the best care possible to the consumers we serve. We look forward to making the recommended changes that will improve the services we provide.

Enclosed you will the Plan of Correction. If you have any questions, please call me at (919) 387-1011 ext. 217. Again, thank you for your time and patience.

Sincerely,

Gary J. Ricci II, BA/QP
Program Manager, CANC

Enclosures