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 01/31/2023

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 A revisit was conducted on 1/31/23 for all previous deficiencies cited on 10/25/22. All deficiencies were not corrected and new non-compliance was found. The facility is not in compliance with all regulations surveyed.	W 000		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 2 audit clients (#3) was provided the opportunity of choice. The finding is: During morning observations in the home on 1/31/23 at 8:51am, client #3 stood up from off the couch in the living room where he was sitting. At 8:52am, Staff C verbally told client #3 to sit down. Further observations revealed client #3 just stood up and was not walking anywhere. Additional observations revealed at 8:53am, client #3 stood up again from the couch and when he did Staff C verbally told him to sit down when he took a couple of steps away from the couch. Staff C first took hold of client #3's right wrist and then his left wrist, as client #3 attempted to take a couple of more steps. Staff C let go of client #3's wrist and then put his hand on the right should of client #3 and pushed him towards the couch and told him to sit back down. During an immediate interview on 1/31/23, when asked why he was verbally and physically having client #3 to sit back down on the couch, Staff C	W 247		

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

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W 247	Continued From page 1 stated he did it because client #3 was going to walk up to the surveyor and grab at them. When asked if it was written in client #3's plan to physically have him sit down, Staff C stated it was not. Again when asked why he was having client #3 sit down whenever he stood up, Staff C repeated how client #3 will just come over and touch anyone who enters into the home. As Staff C was being interviewed by the surveyor, another client stood up from their chair and walked over to where the surveyor and Staff C where at. Staff C raised both of this hands and placed them on the shoulders of the other client and pushed his back towards the chair and verbally told him to sit down. During an interview on 1/31/23, the Qualified Intellectual Disabilities Professional (QIDP) revealed client #3 can move around freely within his own home. The QIDP reported there should not be any time when a staff should be physically directing a client to sit down.	W 247		
{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	{W 249}		

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{W 249}	Continued From page 2	{W 249}		

interviews, the facility failed to ensure 1 of 2 audit clients (#6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of personal care. The finding is:

During morning observations in the home on 1/31/23 at 7:31am, client #6 walked over to the surveyor asking for a cigarette. Further observations revealed the surveyor backed up from client #6 as he reached out for the surveyors' wrists. Client #6 reached out and grabbed the surveyors' left wrist and squeezed with his right hand. As client #6 was squeezing the surveyors' left wrist his nails began to dig into their skin. Staff A then walked over and verbally redirected client #6 to let go of the surveyor's wrist. After client #6 left go of the surveyor's wrist, they noticed that their skin was torn where client #6 had grabbed them. Additional observations revealed the skin was broken and bleeding.

During an interview on 1/31/23, Staff B stated staff are responsible for filing down client #6's nails.

Review on 1/31/23 of client #6's Community/Home Life Assessment dated 12/16/22 revealed there was no information about how or who does the nail care for client #6.

During an interview on 1/31/23, management staff reported nail care should be part of daily grooming for client #6.

Based on observations, record reviews and interviews, the facility failed to ensure 1 of 3 audit

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{W 249}	Continued From page 3	{W 249}		

clients (#6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of medication administration. The finding is:

During morning medication administration in the home on 10/25/22 at 7:22am, Staff A spoon fed client #6 his medications. Additional observations revealed Staff A did not prompt client #6 to spoon fed himself his own medications.

During an interview on 10/25/22, Staff A stated he spoon fed client #6 his medications because he will spit them out. Further interview revealed if client #6 spits out his medications the staff will have to fill out a form indicating a pill or pills were spit out.

Review on 10/24/22 of client #6's IPP dated 12/17/21 indicated he can feed himself.

During an interview on 10/25/22, the Site Manager stated staff should not be feeding client #6 his medications.

During an interview on 10/25/22, the facility's nurse revealed client #6 can feed himself his own medications. Further interview revealed staff should be giving client #6 as much independence as possible during medication administration.

During an interview on 10/25/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6 should not have been spoon feed his medications.