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 _____	09/11/2024

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 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: The facility failed to assure the individual support plan (ISP) for 1 of 3 sampled clients (#6) included objective training to meet the client's dining needs as evidenced by observation, interview, and record verification. The finding is: Afternoon observations in the group home on 9/10/24 at 5:33 PM revealed client #6 to sit down at the table for supper along with a peer while the other clients in the home were made to wait. The client was observed to use a regular spoon, high-sided divided plate and a cloth shirt protector while eating his pureed diet textured meal. The client was observed to scoop bites quickly into his mouth with large amounts of spillage on his shirt protector and his chin while eating. Further observations during client #6's meal revealed staff to stand beside the client for some of the meal and verbally prompt the client to slow down. Continued observations revealed the client to have food on his chin until he finished eating and staff prompted him to wipe his mouth which he was able to do independently after the prompt. Morning observations in the group home on 9/11/24 at 6:30 AM revealed client #6 to sit down to breakfast and immediately start eating a prepared plate of pureed food. The client was again observed to eat at a rapid pace using a spoon, high-sided sectioned plate and a shirt protector. Staff were again noted to verbally prompt the client to slow down and were	W 227		

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

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W 227	Continued From page 1 occasionally noted to stand beside the client while he ate to assist the client with serving himself or to prompt him to slow down. Subsequent observations revealed the client to sit by himself to eat while the other clients waited 15 minutes longer to come to the table. The client was observed to demand more food as the other clients ate and was given multiple servings. Additional observations of the client after he finished breakfast revealed the client to again have a large amount of spillage on his chin and on his shirt protector to the point that it soaked through and wet his shirt. Interview with the site supervisor (SS) revealed client #6 eats earlier that the other clients as he will grab their food which is a choking hazard as it is not his diet consistency. Review of client #6's ISP dated 12/14/23 revealed the client to be edentulous and on a 1500 calorie pureed diet. Further review of the ISP, substaniated by interview with the qualified intellectual disabilities professional (QIDP), revealed client #6 to have a new behavior support plan addendum dated 9/10/24 to address client #6's grabbing others food. However, continued review of the ISP revealed no objective training is currently included to increase the client's dining skills to meet his many needs.	W 227		
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: The facility failed to assure the individual support plans (ISPs) for 5 of 6 client in the group home	W 247		

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W 247	Continued From page 2 (#1, #2, #3, #4 and #5) included opportunities for choice and self-management regarding meal times as evidenced by observation, interview and record verification. The findings are: A. The facility failed to allow for client choice and self-management regarding eating times. For example: Afternoon observations in the group home on 9/10/24 at 5:33 PM revealed client #6 to sit down at the table for supper along with client #3 while the other clients in the home were made to wait. Client #6 was observed to eat at fast pace while eating his pureed diet textured meal. Client #3 also was observed to eat a pureed consistency meal. Further observations revealed while the two clients ate their meal, the other clients were observed to have to wait in the the living room or their bedrooms until 5:45 PM when they were prompted to go wash their hands for supper. As clients #1, #2, #4 and #5 finished washing their hands they were seated at the table to begin serving themselves supper. Morning observations in the group home on 9/11/24 at 6:30 AM revealed client #6 to sit down to breakfast and immediately start eating a prepared plate of pureed food. The client was again observed to eat at a rapid pace. Continued observations revealed the client to sit by himself to eat while again the other clients waited 15 minutes longer to come to the table. Interview with the site supervisor (SS) revealed client #6 eats first as he will grab others food when he notices that he has a different consistency than most of his peers. Further interview revealed the group home has managed	W 247		

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W 247	Continued From page 3	W 247		

this behavior by starting client #6's meal before everyone else even though their food is ready and they are not given a choice to be able to eat immediately. Review of client #6's ISP dated 12/14/23 revealed a new behavior addendum program dated 9/10/24 to start addressing the client's food grabbing behaviors. However, further review of the ISP revealed no training or active treatment interventions regarding the need for client #6 to eat first while others choice and self-management regarding their meal times is limited.

B. The facility failed to allow for client choice and self-management regarding eating the food which he prepared. For example:

Morning observations in the group home on 9/11/24 at 6:10 AM revealed client #3 to be in the kitchen with Staff A preparing his breakfast. Staff A and client #3 were observed to prepare cereal and toast before using the food processor to blend each food item into a pureed consistency. The cereal and toast were then placed on a high-sided sectioned plate along with applesauce. Client #3 was observed to have a bib placed on him and start to carry his plate to the table at 6:30 AM. Continued observations, however, revealed staff to take the client's plate from him, removed his shirt protector and prompt him to the living room. Staff were then observed to give client #3's prepared plate to client #6 who sat at the table and started eating it rapidly. Interview with the SS revealed client #6 has a morning medication that is required to be taken with food and he had just finished taking his medications. Interview with Staff A, who had been assisting client #3, revealed she was helping client #3 to puree and prepare the breakfast so client #3

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W 247	Continued From page 4 could go ahead and start eating instead of handing the plate to client #6 even though they are both on the same pureed diet. Client #3 was not afforded choice and self-management regarding his breakfast as he was not allowed to eat the breakfast that he prepared for himself and was made to wait to eat until 15 minutes later with his other peers when he had to go and remake his pureed breakfast again.	W 247		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: The facility failed to assure that a technique to manage the behavior of 1 of 3 sampled client (#6) was not used as a substitute for an active treatment program as evidenced by observation, interview and record verification. The finding is: Afternoon observations in the group home on 9/10/24 at 5:33 PM revealed client #6 to sit down at the table for supper along with client #3 while the other clients in the home were made to wait. Client #6 was observed to eat his pureed food rapidly and the other clients in the home were made to wait until the client had finished 15 minutes later before they were prompted to wash their hands and sit down at the table for supper. Morning observations in the group home on 9/11/24 at 6:30 AM revealed client #6 to sit down to breakfast and immediately start eating a prepared plate of pureed food. Further observations revealed the client to sit by himself	W 288		

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W 288	Continued From page 5 to eat while the other clients waited 15 minutes longer to come to the table. The client was observed to demand more food as the other clients ate and was given multiple servings. Interview with the site supervisor (SS) revealed client #6 eats earlier than the other clients except for client #3 as they are both on a pureed diet and client #6 will grab at others food when he realizes they are getting a different consistency than he is. Further interview with the qualified intellectual disabilities professional (QIDP), substantiated by review of client #6's individual support plan dated 12/14/23, revealed the client to have a new behavior addendum dated 9/10/24 to address the client's food snatching behaviors. However, further interview and review of the client's ISP revealed no objective training or active treatment program is tied to the group homes technique of isolating client #6's meals by making the other clients wait to eat to address the client's behaviors around mealtimes.	W 288		