PRINTED: 02/13/2019 FORM APPROVED

		THE CHANGE				CINID Mr	7, 0938-0397
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DÁTE COMP	SURVEY LETED
•	à	34G315	B, WNG			1	d datamin
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	57	FREET ADDRESS, DITY, STATE, ZIP CODE	021	12/2019 .
CORBEL	CORBEL RESIDENTIAL			48	RRUM, NC 28369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST DE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IE ATE	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	3	W	000			
	#NC00147144. The unsubstantiated.	Complaint was					
W 220			W	220			nts 4/12/9
	CFR(s): 483,440(c)(;	3)(v)			W 220 The facility will ensure that	t all clie	nts 4/1
	44	6 m - 17			assessments upon admission to fa	arility ai	re
	Ine comprehensive	functional assessment must anguage development,			assessments upon authoritor to the	transport as	nd (10
	Illelade speech and t	anguage development,		1	completed within first 30 days. N	iuises a	וונג בעו
		•			will monitor weekly new client ac		1
	The facility failed to plan (PCP) for 1 of 3 included assessmen language developments.	not met as evidenced by: assure the person centered sampled clients (#6) t of the client's speech and ent and needs as evidenced ord verification. The finding			assessments during first 30 days.	,	
	Client #6's Interdisch	ollnery team falled to obtain					" 16
		s speech and language					for Unan
		admission to the facility.			Nurses will schedule speech asses		
		•			client #6 and follow up with appo	intment	:. Q P
		f client #6's record revealed			will follow up to ensure appointm	ent was	;
	evaluations were cor	he facility on 3/20/18. Several mpleted in conjunction with I to include: Psychological			completed.	v	
		ed 2/3/18), Nutritional					
		3/18), Adaptive Basic			RECEIVED		
	Inventory (ABI) (com	pleted 3/25/18), Physical			400 0 1 2010		
	therapy evaluation (completed 1/28),			APR 0 2 2019		
	Occupational therap	y (completed 1/28), There			21102 11111		
	was no speech and i	anguage evaluation in client			DHSR-MH Licensure \$	Seci	
	#6's record.				-		'
	Interview on 2/12/10	with the qualified intellectual					
		ng/(DIDP) revealed she	1				
			<i>Y</i> /				
LABORATORY	DIRECTOR'S OR PROVIDER	ELPPKIER REPRESEMATIVE'S SIGNATUR	19//	nining beryage	TITLE	······································	(X8) DATE
t. s		The state of the s	11911	***************************************	Descent To I	11.	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other eafeguards 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 perticipation.

FORM CMS-2587(02-89) Provious Versions Obsolute

Event ID; 572311

Facility ID: 945333

If continuation sheet Page 1 of 8

PRINTED: 02/13/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			EURVEY LETED
•	•	34G315	B, WING			1) Inimada
NAME OF PI	ROVIDER OR SUPPLIER	Lawyensyllaborates (1994) Lawrence and a second a second and a second		87	REET ADDRESS, CITY, STATE, ZIP CODE	02/	12/2019
CORBEL	RESIDENTIAL				3 Creek Road Rrum, NC 28369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XE) COMPLETION DATE
W 220	could not locate the s #8: She confirmed cli facility on 3/20/18. Interview on 2/12/19 (Intermediate Care F speech assessment I after client #8's admir INDIVIDUAL PROGE CFR(s): 483.440(c)(4)	with the regional ICF acility) director revealed a nad not been completed selon. RAM PLAN admission, the a must prepare, for each			W226 The facility/interdisciplinar ensure that all clients have an ind program plan within 30 days of ac	ividuaļ	unarth.
FORM CARD. 25	This STANDARD is Based on record revialled to assure the inprepared en individual days after admission ewily admitted audit Client #6's individual developed within 30. Review on 2/12/19 on the was admitted to the evaluations were conclient #6's admission evaluation (complete evaluation (dated 4/6 inventory (ABI) (complete evaluation) (ABI) (complete evaluation) (accupational therapy evaluation) (interview on 2/11/19)	not met as evidenced by: riew and interview, the facility nterdisciplinary team al program plan (IPP) within ion into the facility for 1 of 1 client (#6). The finding is: program plan (IPP) was not days after admission. f client #6's record revealed ne facility on 3/20/18, Several npleted in conjunction with to include: Psychological id 2/3/18), Nutritional 3/18), Adaptive Basic pleted 3/25/18), Physical completed 1/28), y (completed 1/28). with the qualified intellectual			QP will complete all IPP plans with days of admission and there on a	nually	
FORM CM8-256	37(02-99) Previous Versions Ob	soleta Event (D:57	'Z311 ·	Fac	citily ID: 945333 If con	tinuation at	eci Page 2 of 8

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/13/2019 FORM APPROVED

- Chara Limit	S FUR WEDICARE &	MEDICAID SERVICES			OMB NO	. 0938-039
	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COMP	SURVEY
•		349315 .	B. WNO		į	3
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDREBS, CITY, STATE, ZIP CODE	<u> 112/</u>	12/2019
conner :	m markmativi a s		1 .	CREEK ROAD		
LUKBEL I	RESIDENTIAL		ORI	RUM, NC 28369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 226	Continued From page	a 2	W 226	•		
		nal (QIDP) revealed she	WEEG			•
ana sa as sa	could not locate the l	ndividual program plan (IPP) her confirmed client #6 was				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
•	(Intermediate Care F IPP meeting was hel	with the regional ICF acility) director revealed the d in April 2018 but he could			·	
	#6.	document or IPP for client				
W 249	1	ENTATION .	W 249			
	CFR(s): 483.440(d)(1)		W249 The facility will ens	مأسحت تلسمالة سيرر	
·	formulated a client's each client must reconstruction treatment program conterventions and send frequency to support to s	disciplinary team has individual program plan, eive a continuous active consisting of needed ryices in sufficient number oport the achievement of the individual program		receives a continuous acti consisting of needed inter services identified in the I	ve treatment ventions/too	plan برياً
	Based on observation reviews, the facility folients (#2, #6) receit treatment plan consist and services as identification program plan (IPP) is serviced.	not met as evidenced by; ons, interviews and record ailed to ensure 2 of 3 audit ved a continuous active sting of needed interventions atified in the individual n the areas of toothbrushing.		,		
	The findings include			 Habilitation Specialist w staff members on client 		all Mark
		DCS) falled to implement thing objective as written.		brushing goal steps. Pro	gram Manag	er
•		1/19 at 4:50pm of client #2's led he and a DCS walked to	, and the second	weekly and QP will mon		
		•				1

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PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA : IDENTIFICATION NUMBER;	1 ' '		иот эти	(X3) DATE SURVEY COMPLETED	
4		34G316	B. WNG		,	000	
NAME OF PR	Account of the state of the sta			12/2019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID . PREFII TAG		Provider's Plan of Correct (Each Corrective Action Shol Crosş-Referenced to the Appr Deficiency)	JLD BE	(X3) COMPLETION DATE
W 249	DCS was holding a v toothpaste on his toothpaste on his too his teeth. He brushed teeth and briefly brushed. This lasted about rinsed his toothbrush client #2 and DCS is asked DCS if client #DCS stated, "Probab Review on 2/12/19 o 8/13/18 revealed an brush his teeth for 2. Review of the object taken and this object information on the object information on the object information on the object information on the object information on this object information on this object information on this object information on the object inform	a toothbrushing supplies. Instruction Client #2 put Ithbrush and began to brush It his front lower and upper Ithed his lower right and left Int 60 seconds. Client #2 I and left the bathroom. As If the bathroom, the surveyor I had brushed for 2 minutes, Ity not." If client #2's IPP dated Indipertive to independently Influtes for 30/30 sessions. Ive revealed data was being Ive is current. There was no Indipertive indicating how staff I ent #2 brushes his teeth for with the qualified intellectual Inal (QIDP) revealed DCS In the objective as written. She I man as written. If 19 at 4:20pm revealed DCS I dement client #6's I mas written. If 19 at 4:20pm revealed DCS I to retrieve his I es and go to the bathroom to I walked to the bathroom,	w:	249	Habilitation Specialist will staff members on client #6 brushing goal steps. Progr and Habilitation Specialist weekly and QP will monito	5's tooth am Manage will monito	مر ^{ری} er

FORM-CMS-2567(02-99) Previous Versions Obsolete

Event ID: 572311

Facility ID: 845333

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STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE BURVEY COMPLETED	
. ¥	•	34G315	B. WNG	-delibility part	the same of the sa	i	C 12/2019
NAME OF PROVIDER OR SUPPLIER CORBEL RESIDENTIAL				48	REET ADDRESS, CITY, STATE, ZIP CODE 13 CREEK ROAD RRUM, NC 28369	1	122018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X8) COMPLETION DATE
W 249 W 368	program revealed, "V 2 minutes 30 consect Interview on 2/12/19 client #6's written tra should be implement interview revealed th how to accurately the #6 prefers for DCS in bathroom.	Vili tolerate toothbrushing for utive days:" with the QIDP revealed ining program is current and sed as written. Further a team had not considered as toothbrushing when client of to accompany him into the		249			
	The system for drug that all drugs are add the physician's order This STANDARD is Based on observation	administration must assure ninistered in compliance with			W368 The facility will ensure that administered in compliance with porders.		
	Clients (#2). The find Physician's orders for were not followed. During observations 2/12/19 direct care of following to client #2 Vitamin D3 1,000 mg Nexium 20 mg. (1), A Amilodipine 2.5 mg. of topically to both feet medications were or applesauce except f	of the medication pass on staff administered the staff administered the Risperidone 1 mg. (1), one a day vitamin (1),			Nurses will train and in-service al appropriate mixture methods wi medications based on client spec consistency orders. Nurses and F Managers will monitor weekly. O monthly.	th liquid lific diet Program	4-12-19

FORM CMS-2587(02-99) Previous Versions Obsolate

Event ID: 572311

Facility ID: 945333

If continuation shout Page 5 of 8

PRINTED: 02/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION . A. BUILDING		(X3) DATE SURVEY COMPLETED	
•	•	34G315	E. WING			000	; 12/2019
	ROVIDER OR SUPPLIER			48	REET ADDRESS, CITY, STATE, ZIP CODE 3 CREEK ROAD RRUM, NC 28369	U.Z.I	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	ζ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION BHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
W 368	11/14/18 revealed: R D3 1,000 mg. (1), Or 20 mg. (1), Aspirin 8	f the physician orders dated isperidone 1 mg. (1), Vitamin ee aday vitamin (1), Nexium 1 mg. (1), Amiodipine 2.5	W	368			
,	and Lactulose 30ml. Review on 2/12/19 o program plan (IPP) o healthy Diet with pur thickened liquids.	ntment topically to both feet f client #2's Individual lated 8/13/18 revealed; Heart eed food with pudding					
	evaluation dated 10/ healthy diet with pun thickened liquids. " C	f client #2's nutritional 24/18 revealed: Heart sed food with pudding Ongoing monitoring of need d liquids. Incréased risk for		;			
W 369	confirmed all liquids pudding thickened of direct care staff coul the applesauce for in	NOITE	W	369			
,	that all drugs, includ	administration must assure ing those that are e administered without error.			W369 The facility will ensure that be self-administered without errobased on physician's orders.		
	Based on observati interview, the facility medications were ac	not met as evidenced by: ons, record review and failed to ensure client #4's iministered without error, olients (#4). The finding is:					

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 572311

Facility ID; 845333

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If continuation sheet Page 8 of 8

PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-0391

		1.	THE SERVICE OF THE SE					. 0800-0001
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLJA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			,	(X3) DATE SURVEY COMPLETED	
,		34G315	B. WING					
		540710	0, 11110	-			02/	12/2019
	ROVIDER OR BUPPLIER RESIDENTIAL			48:	REET ADDRESS, CITY, STATE, ZIP CODE 3 CREEK ROAD RRUM, NC 28369	,		
(X4) ID	TO VOLUMNO	ATEMENT OF DEFICIENCIES	lb lb	└──Т	PROVIDER'S PLAN OF COR	DECTION	<u> </u>	0.15
, PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	a duuoHa		COMPLETION DATE
W 369	Continued From page	9 6	W	369	,			
	were not administere a) During observation pass of revealed direct care Seroquel 200 mg. (1	ons of the medication on 2/11/19 at 3:40pm staff administered client #4), Seroquel 100mg. (1), 1) and Systane eye drops (1)		;	Nurses will train and in-ser appropriate medication ad for client #4. Nurse will mo will monitor monthly.	ministr	ation or	ders
	dated 11/14/18 rever Seroquel 100mg. (1) Systane eye drops (2 Interview on 2/12/19 revealed this physici Medications should i	oe administered within an		,				
	She also confirmed of received 2 drops to of b) Observations of b	our after the prescribed time. client #4 should have each eye. reakfast on 2/12/19 revealed ting mealtime at 8:05am.	and the state of t					
	#4 received the folio Synthroid 50meg. (1 Valproic Acid ER 25i (1), Metoproid 50 m Seroquel 100 mg. (1 Tiagabline HCL 40m (1), Ziprasidone 80 r sprays to each nostr drops to each eye, N	of the medication on 2/12/19 at 8:10am client wing: Clonazepam 1mg. (1),), Metformin 500 mg. (1), 0 mg. (1), Lisinopril 20mg. g. (1), One a day vitamin (1),), Seroquel 200mg. (1), g. (1), Vitamin D3 1,000mg. mg. (1), Fluticasone spray (2) ril, Systane eye drops (2) Miralax powder (1) capful with nd Chlorhexidine (1) cupful						

FORM CM6-2567(02-89) Previous Versions Obsolate

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Event ID: 572311

Facility (D: 1145333

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12:32:33 p.m. 04-02-2019

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

PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION ,	(X3) DATE SURVEY COMPLETED	
	' ·		and fall blocks. We come to the sub-thick and out of Arraps of property and the sub-thick and the sub-	С		
***************************************		349315	B, WNG		02/12/2019	
	ROVIDER OR BUPPLIER	ener () in historia (met avince) () i c. New	-41	treet.address, city, state, zip code	والمراق والمرافعة والمحاومة فيها والمستحدث أوبا والمحافظة المنسول المستحد	
(54) 10 (64) 10 (64) 10 (64)	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS REFERENCED TO THE APPROPRI DEFICIENCY)		
W 369	Review on 2/12/19 of revealed: Clonazepa 50mcg. (1), Valproio Lisinopril 20mg. (1), I day vitamin (1), Sero 200mg. (1), Tiagabin 1,000mg. (1), Ziprasi spray (2) sprays to edrops (2) drops to ea capful with 8 ounces (1) cupful mouthwas give twice daily before interview on 2/12/19 revealed client #4's I be administered before have been trained to	of client #4's physician orders am 1mg. (1), Synthroid Acid Er 250 mg. (1), Metaprolol 50 mg. (1), One a quel 100 mg. (1), Seroquel e HCL 40mg. (1), Vitamin D3 done 80 mg. (1), Fluticasone ach nostril, Systane eye ich eye, Miralax powder (1) of water and Chlorhexidine ich and "Metformin 500mg. (1)	W 369	Jergeway)		
FORM CMB-25	67(02-99) Previous Versions O	bsolete Event ID: 5723		acility ID: 945333	ntinuation about Days 0 at 0	