STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G123	A. BUILDING _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ATRIUM/THE RESPITE CENTER	101 HORIZONS LANE RURAL HALL, NC 27045

(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: Based on observation, record review, and interview, the facility failed to ensure the individual program plan (IPP) included training to address client needs relative to wheelchair use and safety for 1 of 8 sampled clients (#30). The finding is: Evening observations in the facility on 2/4/20 from 5:45 PM to 6:45 PM revealed client #30 to sit in the activity room watching a movie with staff. Further observations revealed both feet of client #30 to be unstrapped from the footrests and his left foot resting between the footrests. Continued observations at 6:45 PM revealed client #30 to pull his left foot from between the footrests temporarily until it slipped back between the footrests. At no point during the observation period did staff assist client #30 with removing his left foot from between the footrest and strapping his feet securely on either footrest. Morning observations in the facility on 2/5/20 revealed client #30 to transition from the breakfast meal to the activity room and to participate in various activities. Further observation revealed client #30 to have both feet securely strapped to his footrests throughout the morning observation period. Review of the client record on 2/5/20 revealed an	W 227		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ATRIUM/THE RESPITE CENTER	101 HORIZONS LANE RURAL HALL, NC 27045

(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	Continued From page 1 individual program plan (IPP) dated 9/24/19. Further review of the client record revealed a physical therapy (PT) assessment dated 9/16/19 which identified the following adaptive equipment: chest strap, tilt table, wheel chair, and knee immobilizers which are used to increase mobility and safety during transfers. Continued review of the client record on 2/5/20 revealed a PT wheel chair assessment dated 10/14/19. Review of the client record for client #30 did not reveal any objectives or guidelines relative to wheelchair use and transfers. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/5/20 verified that client #30 has no comprehensive guidelines or objective training relative to wheelchair use, transfers, or safety. Continued interview with the QIDP confirmed that client #30 could benefit from training objectives and guidelines to address the client's needs to ensure wheelchair safety.	W 227		