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	DHSR-Mental Health FEB 26 2020 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew James	Director of Operations	2-20-2020

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
	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	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		

40 Years of Compassionate Care for Exceptional People

HORIZONS
Residential Care Center

100 Horizons Lane • Rural Hall, NC 27045 • (336) 767-2411 • Fax (336) 661-2185

Plan of Correction (POC) Horizons Residential Care Center- Arches

Survey Completion Date: 02/05/2020

Submitted Date: 2/18/2020

Introduction

Thank you for your recent visit to Horizons Residential Care Center. We appreciated the feedback that you shared with us. We have used your feedback to address areas of need and improvement in our delivery of services to our clients. Please see our specific actions, detailed below, to rectify the deficiencies that were noted. We look forward to your continued input and involvement with our agency.

All the best,

Matthew James

Operations Director, Horizons Residential Care Center

Tag and POC

W227. In response to this deficiency- Horizons will develop and ensure that the individual program plan includes training guidelines specific to wheelchair use and safety. All Direct Support Professional staff assigned to the unit will be in-serviced on these guidelines by March 6th, 2020. These

guidelines will be outlined in the revised IPP and included in the electronic health record for accessibility.

Conclusion

Thank you again for the detailed feedback that supports our improvement of service delivery. While external feedback is important to ensure the provision of excellent services, we as an organization understand the necessity to continuously monitoring internally and address areas of need. We value the input of both external and internal sources that lead to better quality of life outcomes for the individuals our agency supports. We hope you find the detailed plans of correction sufficient.

All the best,

2-20-2020

Matthew James

Operations Director, Horizons Residential Care Center

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

February 14, 2020

Horizons Residential Care Center-The Atrium
Richard Anderson, President/CEO
Matthew James, Director of Operations
101 Horizons Lane
Rural Hall, NC 27045

Re: Recertification Completed February 5, 2020
The Atrium-The Respite Center
Provider Number 34G123
MHL# 034-016
E-mail Address: Matthewj@horizonscenter.org

Dear Mr. James:

Thank you for the cooperation and courtesy extended during the recertification survey completed February 5, 2020. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is April 4, 2020.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Clarissa Henry at 704-589-2523.

Sincerely,

Clarissa Henry, MHSA, QP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: qmemail@cardinalinnovations.org
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QM@partnersbhm.org
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File