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 _____	C 06/02/2021

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 000	INITIAL COMMENTS A complaint survey for intakes #NC00177416, #NC00176706, #NC00176678 and a recertification survey were conducted on 6/1/21 and 6/2//21. Deficiencies were not cited as a result of the recertification survey.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on facility record/document review and interviews, the facility failed to ensure an injury and investigation relative possible abuse and/or neglect was reported to external officials in accordance with state law for 1 of 1 investigation reviewed. The finding is: Review of facility investigations on 6/1/21 revealed an investigation summary dated 3/8/21. The scope of the investigation was to rule out abuse and/or neglect. Review of the internal investigation summary dated 3/8/21 revealed the nurse was called to the bathroom upon report of client #8 falling out of the lift during a transfer from his wheelchair to the changing table. Continued review of the investigation summary revealed upon the nurse entering the room, client #8 was observed to be on the floor and staff A standing next to the client. Further review of the summary revealed the lift was in an elevated	W 153		

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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W 153	Continued From page 1	W 153		

position with three loops connected and one was not. Subsequent review revealed the client was crying and voluntarily moving his head and arms. Additional review revealed neuro checks were within normal limits with no bleeding or other injuries noted. The investigation summary also revealed the doctor of physical therapy (DPT) and physical therapist (PT) were notified and observed the same.

Ongoing review of the internal investigation revealed a clinical decision was made to have the client #8 evaluated at the hospital due to a fall from an elevated distance. Review of the investigation summary subsequently revealed client #8 was seen at Wake Forest Baptist Health on 3/8/21 where a CT head scan was completed with no injury noted. Client #8 was noted to have been released from the hospital with recommendations to follow up with his primary care provider as needed if symptoms worsen.

A review of incident notifications revealed the chief executive officer (CEO), director of operations (DOO) and client #8's guardian were notified on 3/8/21. Further investigation review revealed no evidence of a report completed within the Incident Response Improvement System (IRIS).
A review of the conclusion from the 3/8/21 investigation revealed additional guidelines were implemented and an in-service with all staff was conducted on 3/31/21. Continued review of the in-service training revealed the training to include protocols relative to resident falls and positioning. Further review of the investigation conclusion revealed the facility followed internal protocol and obtained medical treatment timely.

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W 153	Continued From page 2 Interview with the facility qualified intellectual developmental professional (QIDP) on 6/2/21 verified an unsubstantiated finding of abuse and/or neglect with the 3/8/21 internal investigation. Continued interview with the facility QIDP revealed an IRIS report had not been completed with client #8's incident on 3/8/21 and a report should have been completed.	W 153		