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	DHSR - Mental Health JUL 2 2021 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Director of Clinical Services	6-25-21

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 _____	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 153	Continued From page 1 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.	W 153		

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 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	On 6/3/21 Retraining Occurred with QIDP's in regards to Abuse, Neglect & Exploitation policy. Review IRIS protocol & procedure. Alissa RW.	6/3/21

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

June 11, 2021

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 June 2, 2021
The Atrium-The Respite Center
Provider Number 34G123
MHL# 034-016
E-mail Address: Matthewj@horizonscenter.org
Complaint Intake: NC00176678, NC00176706, NC00177416

Dear Mr. James:

Thank you for the cooperation and courtesy extended during the recertification survey and complaint survey completed June 2, 2021. 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 August 1, 2021.

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 me at (828) 750-2702.

Sincerely,

Shyluer Holder-Hansen
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: qmemail@cardinalinnovations.org
DHSR@Alliancebhc.org
QM@partnersbhm.org
dhhs@vayahealth.com
_DHSR_Letters@sandhillscenter.org
File

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

Survey Completion Date: 06/02/2021

Submitted Date: 6/29/2021

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.

Regards,

Amanda Kiser RN BSN

Director of Clinical Services

Horizons Residential Care Center

Tag and POC

W153. In response to this deficiency- Horizons has retrained on the Abuse, Neglect, and Exploitation policy including IRIS reporting to all of our Leaders on Call, our QIDPs, and Shift Supervisors. IRIS reporting capability was extended to all Leaders on Call to help support compliance in this matter. Previously this was limited to QIDPs only. The Abuse, Neglect, and

Exploitation policy was updated so the Director of Clinical Services and Director of Operations are notified immediately of any suspected activity. This way the investigation process can be monitored and coached from start to finish. A safeguard and monitoring system put in place to ensure completion and accurateness of investigations, is that the executive team will have a debriefing at the conclusion of all investigations to ensure all needed information was obtained, documented and reported accordingly.

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 monitor 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.

Regards,

Amanda Kiser, RN BSN

Amanda Kiser RN BSN

Director of Clinical Services

Horizons Residential Care Center