STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G315	A. BUILDING ______ B. WING ______	C 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORBEL RESIDENTIAL	**483 CREEK ROAD** **ORRUM, NC 28369**

(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 was completed on November 22, 2022 for intake #NC00194724. Deficiencies were cited.	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 record review and interviews, the facility failed to immediately notify the administrator and law enforcement once discovering an injury of unknown origin, with an additional allegation of physical abuse. This affected 1 of 1 audited clients (#3). The finding is: Record review on 11/22/22 of client #3's incident report, which took place the morning of 10/20/22, revealed a behavior incident that involved Staff A. The report revealed that client #3 was trying to go outside and Staff A tried to prevent him, for unknown reasons. Staff A alleged that client #3 tried to hit her when he became upset that he could not go outside. Staff B entered the home at 8:40am and found client #3 still on the floor and assisted him up. Client #3 told Staff B that Staff A had pushed him down. Staff C arrived to work, at unknown time and learned from Staff A that she pushed down client #3 when he tried to hit her. None of the staff on duty informed the administrator of the incident between client #3 and Staff A.	W 153		

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

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.

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W 153	Continued From page 1 An additonal record review of the incident report on 11/22/22 revealed the the nurse was contacted on 10/20/22 during the evening bath by Staff D who observed that client #3 had pain in his right thumb. The nurse advised Staff D to send client #3 to the emergency room for evaluation and treatment. Client #3's thumb was x-rayed and diagnosed with a Bennett Type fracture. Interview on 11/22/22 with the nurse revealed she was "on call" on 10/20/22 when she received a phone call from Staff D at 6:30pm. Staff D revealed that client #3's hand was swollen and red. Interview on 11/22/22 with the Clinical Supervisor (CS) revealed she did not receive a call on 10/20/22 during 1st shift, that Staff A admitted to pushing client #3 to the ground. The CS stated that originally she did not view the incident as physical abuse and did not file a police report. Interview on 11/22/22 with the Quality Management Director (QMD) revealed she was not contacted by any staff immediately after the incident was discovered. The QMD acknowledged that she was aware there was a reporting requirement to contact the police for allegations for physical abuse but did not handle that part of the investigation.	W 153		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by:	W 156		

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W 156	Continued From page 2 Based on record review and interviews, the facility failed to report an investigative summary to law enforcement within five days of their abuse investigation. This affected 1 of 1 audited client (#3). The finding is: Record review on 11/22/22 of client #3's incident report, which took place the morning of 10/20/22, revealed a behavior incident that involved Staff A. The report revealed Staff A tried to prevent client #3 from going outside, he became upset, tried to strike her and Staff A pushed him to the ground. Client #3 sustained a Bennett type fracture to right thumb from being pushed to the ground. Interview on 11/22/22 with the Clinical Supervisor (CS) revealed originally she did not view the incident as physical abuse and did not file a police report until 11/22/22. Interview on 11/22/22 with the Quality Management Director (QMD) revealed her acknowledgment that she was aware there was a reporting requirement to contact the police for allegations for physical abuse but did not handle that part of the investigation.	W 156		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for	W 508		

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W 508	Continued From page 3 COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have	W 508		

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W 508	Continued From page 4 received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the	W 508		

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W 508	Continued From page 5 authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to secure documentation of the COVID-19 vaccination status for all staff, including contracted licensed personnel. The findings is: Record review on 11/22/22 of the facility's	W 508		

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W 508	Continued From page 6 undated COVID-19 Vaccination Program policy revealed all staff must present proof of having received one dose of COVID 19 or the 1st dose of a multi-dose COVID 19 vaccine by 1/27/22 unless a vaccination exemption or temporary delay as recommended by Center for Disease Control (CDC) had been approved. All staff must have proof of all doses by 2/28/22. Proof of vaccine must be emailed to Human Resources (HR). If staff does not submit proof or exemption, staff cannot provide services. An additional review on 11/22/22 of the list of employees revealed there was no vaccine documentation for the maintenance worker, registered dietician, occupational therapist or physical therapist staff. Interview on 11/22/22 with the HR Business Partner (HRBP) revealed she was unaware they were required to collect proof of vaccination for contracted licensed staff. The HRBP acknowledged they did not have a copy of the maintenance worker's vaccine status.	W 508		