DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2022
FORM APPROVED
OMB NO. 0938-0391

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 ______	08/02/2022

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 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure techniques to manage inappropriate behavior of 1 of 29 clients (#19) were not used for the convenience of staff. The finding is: Observation in the facility on 8/1/22 at 6:06 PM revealed client #19 to be sitting in a wooden chair with arms and to participate in the dinner meal with partial independence. Continued observation at 6:22 PM revealed client #19 to be finished with the dinner meal and for staff to place a velcro strap around the client's waist and the back of the chair. Further observation revealed client #19 to jerk energetically while strapped to the chair and scoot across the room. Observation in the facility on 8/2/22 at 7:00 AM revealed client #19 to be sitting in his wheelchair in the day room. Continued observation in the day room revealed a chair at the dining table with a velcro strap secured around the chair back. Review of records for client #19 revealed a habilitation plan dated 6/12/22. Review of client #19's plan revealed his adaptive equipment includes a wheelchair, gait trainer, right AFO, shoe lifts, and right hand splint. Continued review of the plan indicated client #19 can sit in a regular chair with arms and can get on the floor from the recliner or a chair, he loves to be on the floor and can scoot around.	W 287	Inservice on 9/10/22 on Behavioral Strategies Routine Follow up by QIDP + psychologists. RECEIVED AUG 2 2 2022 DHSR-MH Licensure Sect	9/10/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Kiser RN BSN — TITLE: Director of Clinical Services — (X6) DATE: 8/17/2022

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 287	Continued From page 1 Interview with staff on 8/1/22 and 8/2/22 revealed they utilize the strap to keep client in his chair and will remove it if he begins to jerk too much. Interview with the qualified intellectual disabilities professional (QIDP) on 8/2/22 revealed they were aware of the practice to secure client #19 to the chair. Further interview with the QIDP verified there is no guideline in place that allows for staff to restrict client #19 to the chair and confirmed this practice should no longer be continued.	W 287		
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 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,	W 508	Staff member received second shot that day. 8/2/2022 monthy HR & Clinical Director to reconcil vaccine records.	

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W 508	Continued From page 2 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 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	W 508		

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W 508	Continued From page 3 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 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,	W 508		

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W 508	Continued From page 4 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 implement policies and procedures to ensure all staff are fully vaccinated for COVID-19. The finding is: Review of staff vaccination records on 8/2/22 revealed a staff to receive their first COVID-19 vaccination on 11/23/21 with no indication of the second vaccination dose. Review of the facilities COVID-19 vaccination policy and procedures indicated all staff must be fully vaccinated with the two doses by 1/4/22. Interview with the qualified intellectual disabilities professional (QIDP) on 8/2/22 confirmed the staff has not received their second vaccination. Continued interview with the QIDP revealed the staff is currently working in the facility. Subsequent interview with the QIDP revealed they have instructed the staff to leave the facility to receive their second vaccination.	W 508		

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RECEIVED
AUG 2 2 2022
DHSR-MH Licensure Sect

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

Survey Completion Date: 08/02/2021

Submitted Date: 8/17/2021

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

W287. MGMT OF INAPPROPRIATE CLIENT BEHAVIOR

In response to this deficiency- Staff were immediately retrained on behavioral strategies and use of mechanical restraints for resident #19. A follow up in service to be held on September 10, 2022 on behavioral strategies for all

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 9, 2022

Richard Anderson, President/CEO
Horizons Residential Care Center
101 Horizons Lane
Rural Hall, NC 27045

Re: Recertification Completed August 2, 2022
The Atrium/The Respite Center, 101 Horizons Lane, Rural Hall, NC 27045
Provider Number 34G123
MHL# 034-016
E-mail Address: Richarda@horizonscenter.org

Dear Mr. Anderson:

Thank you for the cooperation and courtesy extended during the recertification survey completed August 2, 2022. 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 October 1, 2022.

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 919-703-5581.

Sincerely,

Chad Sprehe, MA, LCMHC, CI
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

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