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 _____	02/28/2023

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
E 000	Initial Comments A recertification and follow-up surveys were was conducted on 2/28/23. All previous deficiencies cited on 1/27/23 have been corrected; however deficiencies were cited during the recertification survey on 2/28/23.	E 000		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E 015		

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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E 015	Continued From page 1 *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on observations, document review and staff interviews, the facility failed to ensure emergency provisions for subsistence needs for clients and staff included adequate water. This potentially affected all clients in the home (#1, #2, #3, #4, #5 and #6). The finding is: During observations in the home on 2/27/23 at 5:05PM, the pantry had four gallons of water placed on the top shelf in corner where emergency food provisions were placed. A sign below the water read: Emergency food only. Power outages, bad weather, no lights. 3/19/20. Interview on 2/27/23 with Staff A revealed the four gallons was the only water allocated for	E 015		

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E 015	Continued From page 2 emergency provisions. Interview on 2/28/23 with the Regional Director (RD) revealed the home manager was responsible for maintaining emergency food supplies and water. The RD stated that the provisions were not purchased for staff but they should have had 2 to 3 gallons per person (clients) for 7 days.	E 015		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only.	E 022		

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E 022	Continued From page 3 The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to develop policy and procedures for sheltering in place in their emergency plan (EP). This potentially affected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: Review on 2/27/23 of the facility's EP dated 2/27/23 did not include language for situations that would call for the clients and staff to shelter in place. Interview on 2/28/23 with the Regional Director revealed they were still working on developing a shelter in place policy.	E 022		
E 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop	E 036		

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E 036	Continued From page 4	E 036		

and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must

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E 036	Continued From page 5 develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on interview and review of the facility's emergency preparedness (EP) plan, the facility failed to develop an EP training and testing program for staff. The finding is: Review on 2/27/23 of the EP revealed no record of training for direct care staff on the facility's EP plan. Interview on 2/28/23 with the Regional Director revealed she was aware that training was performed but the home manager did not retain the accompanying documents.	E 036		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that all staff were competent in implementing smoking guidelines and safely supervising 1 of 6 audit clients (#1) smoke breaks. The findings are:	W 189		

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W 189	Continued From page 6 Observations at the home on 2/27/23 at 4:16PM, cigarette butts were observed in the grass off the patio and in the cracks between patio pavers. An additional observation at 4:25PM, revealed client #1 light up a cigarette and placed a lighter in his pants pocket while standing on the patio. Staff C and Staff D were present with clients #3, #4 and #5, playing board games. Client #1 stood on the grass behind client #6's bedroom window and allowed cigarette ashes to fall in the grass. There was no ashtray nearby to catch is ashes. The weather was breezy. The wind's miles per hour (MPH) was checked using an online weather app and recorded it at 11 MPH. The property was also surrounded by woods. An additional observation on 2/27/23 at 5:40PM, client #1 finished his dinner and went outside alone to smoke in the designated smoking area by the carport. Staff C left the dinner table and went outside to supervise client #1. At no time, was Staff C observed handing client #1's smoking materials. On 2/28/23 at 8:03AM, client #1 went outside to smoke in the designated smoking area after breakfast. Staff C supervised client #1 while he smoked. At no time, was Staff C observed handling client #1's smoking materials. Staff B and Staff E were present, while client #1 smoked. Review on 2/28/23 of client #1's record revealed an undated document for Smoking Guidelines developed at his former placement. Staff will keep client #1's cigarettes and lighter in a safe place until it is time for him to have a cigarette. Client #1 will not have the cigarettes on his person.	W 189		

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W 189	Continued From page 7 Review on 2/28/23 of the facility's policy on Tobacco Products, dated 8/11/08 revealed: The facility did not allow the use of tobacco products in the presence of an adult consumer who does not use tobacco products. The facility asks that tobacco users observe safe practices including using an ashtray/smoking receptacle and keeping lighter/matches secure. Materials from tobacco use will be extinguished and disposed of in an ashtray/smoking receptacle. Interview on 2/28/23 with the home manager (HM) revealed smoking should take place outdoors in the designated smoking area, outside of the side door, where they have an industrial ashtray. The HM revealed that recently there was a storm that caused the ashtray to fall over and many of the butts fell out of the pan and were blown around the property. The HM said that she uses a "grab it stick" to pick up butts around the property however due to it breaking, she had not done it. Interview on 2/28/23 with the qualified intellectual disabilities professional (QIDP) revealed whenever she visited the home, she saw client #1 smoking behind the house, with staff present. The QIDP revealed that the nurse practioner had offered client #1 a patch to wear to stop smoking but he refused to wear it. The QIDP also revealed that client #1 was able to maintain his cigarettes but staff should have his lighter, so that he does not smoke in non-designated areas. The QIDP stated that she would need to retrain staff on the smoking policy and assure that other clients were not present when client #1 smoked.	W 189		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)	W 263		

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W 263	Continued From page 8 The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 6 audit clients (#1). The finding is: Review on 2/28/23 of client #1's record revealed an undated document for Smoking Guidelines developed at his former placement. The document revealed client #1 would be placed on a smoking schedule for the day program and residential. Staff will keep client #1's cigarettes and lighter in a safe place until it is time for him to have a cigarette. Client #1 will not have the cigarettes on his person. Client #1 is only allowed to smoke one cigarette at each break. At the day program, client #1 was permitted 3 smoke breaks; at the residence he was permitted 2 smoke breaks. On weekends, client #1 was permitted 4 smoke breaks. Review on 2/28/23 of client #1's behavior support plan (BSP) consent, signed on 9/19/22 focused on medications for behavior control and authorized the use of the NCI (non-violent crisis intervention) technique. There was no evidence that the guardian signed a consent to authorize restricting smoking. Interview on 2/28/23 with the qualified intellectual disability professional (QIDP) revealed that client #1 used to chain smoke and had been treated for some health issues when he transferred to the	W 263		

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W 263	Continued From page 9 home last year. The QIDP acknowledged the guardian did have concerns the smoking may contribute to health problems for client #1. The QIDP revealed there was a failed attempt to get client #1 to wear a Nicotine patch for a smoke cessation program. The QIDP revealed that client #1 was put on smoke breaks to assist him to reduce frequency of smoking. The QIDP acknowledged that she never considered this as a restriction to client #1's rights and did not include it on the BSP.	W 263		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to adhere to their COVID-19 policy; and protect other clients from tobacco smoke. This had the potential to affect all clients (#1, #2, #3, #4, #5 and #6). The findings are: A. During observations in the home on 2/27/23 from 3:50PM to 4:03PM, Staff B wore her surgical face mask beneath her nose, while administering medications to client #3 and client #5. An additional observation on 2/28/23 from 8:27AM to 9:00AM, Staff B wore her surgical face mask beneath her nose, while administering medications to client #4 and client #6. Review on 2/28/23 of the facility's staff COVID-19	W 340		

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W 340	Continued From page 10 and exemptions status revealed Staff B was approved for a religious exemption from the COVID-19 vaccine on 12/3/21. The COVID-19 Vaccine policy stated it may include non-vaccinated staff wear a KN95 mask at all times. B. During observations in the home on 2/28/23 from 7:15AM until 8:30AM, Staff G and Staff H were observed wearing their surgical face masks beneath their noses while working with clients #1 and clients #3. Interview on 2/28/23 with the nurse revealed the face mask should cover staff's nose and mouth. Interview on 2/28/23 with the Regional Director revealed face mask should cover the nose and mouth. C. During observations at the home on 2/27/23 at 4:25PM, Staff C and Staff D permitted client #1 to produce second hand smoke outside, in the presence of clients #3, #4 and #5, non-tobacco users. Review on 2/28/23 of the facility's policy on Tobacco Products, dated 8/11/08 revealed: The facility did not allow the use of tobacco products in the presence of an adult consumer who does not use tobacco products. Interview on 2/28/23 with the qualified intellectual disabilities professional (QIDP) revealed that client #1 should only be smoking in the designated smoking area and staff will be retrained to ensure no other clients are present.	W 340		
W 368	DRUG ADMINISTRATION	W 368		

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W 368	Continued From page 11 CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to ensure all medications were administered without error. This affected 3 of 6 audit clients (#1, #4 and #6). The findings are: A. During observations on 2/27/23 at 3:57PM medication administration at the home, Staff B did not administer Systane Balance eye drops to client #4. Review on 2/28/23 of client #4's Physician's Orders signed 2/15/23 revealed a prescription for Systane Balance Eye Drops to be given at 8:00AM, 4:00PM and 8:00PM. B. During observations on 2/28/23 at 7:17AM medication administration at the home, client #1 dropped a Xarelto tablet when opening the pill pack. Staff H was present, retrieved the tablet off the floor and contacted the nurse. At 8:15AM, a call came in from the nurse who advised Staff H to take a Xarelto from the pill pack on 3/2/23 and give to client #1 until she can replace the medication. Staff H notified Staff B, who was now conducting the medication pass, that she needed to give one medication to client #1. Staff B finished giving medications to clients #4 and #6 and then Staff H entered the medication room and gave client #1 the Xarelto at 9:05AM. Review on 2/28/23 of client #1's Physician's Orders signed 2/21/23 revealed a prescription for	W 368		

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W 368	Continued From page 12 Xarelto 20MG at 8:00AM. C. During observations on 2/28/23 from 8:27AM to 8:40AM, Staff B administered medications to client #4. Client #4 took the lock box with controlled medication off the shelf and placed on counter in the medication room. Staff B was not observed opening the box to give client #4 Clonazepam. Client #4 also received one tablet of Liothyronine SOD 5 MCG and one tablet of Synthroid 50MG, after eating breakfast at 7:30AM. Review on 2/28/23 of client #4's Physician's Orders signed 2/15/23 revealed a prescription for Liothyronine SOD 5 MCG was increased to 15 MCG. The Liothyronine and Synthroid were written orders to take at 7:00AM. An additional review on the Quarterly or Periodic Drug Review by the Nurse on 2/15/23 revealed Liothyronine should be given on an empty stomach. D. During observations on 2/28/23 at 8:43AM, Staff B administered medications to client #6. Client #6 took Glimepiride 4MG, after eating breakfast at 7:30AM. Review on 2/28/23 of client #6's Physician's Orders signed 2/16/23 revealed Glimepiride 4MG should be given every day before breakfast at 8:00AM. Interview on 2/28/23 with the nurse revealed that client #4's Liothyronine, Synthroid and Metformin were packaged in a separate pack so they could be given at 7:00AM, after his blood sugars are checked. The medications were intended to be given on an empty stomach to help absorption. On 2/15/23 the nurse practioner increased the	W 368		

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 _____	02/28/2023

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

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W 368	Continued From page 13 Liothyronine for client #4 due to abnormal labs. The pharmacy likely delivered new doses on 2/16/23 and staff should have started using the new package with the 15MG dose. The nurse additionally revealed the medications should be given as written to avoid a medication error. The nurse stated that Staff H should have immediately given client #1 the Xarelto at 8:15AM instead of waiting for Staff B to finish her medications. The nurse revealed that she will discuss changing some of the times of clients #4 and #6 medication to ensure it is given before breakfast.	W 368		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure a sanitary environment was provided to avoid transmission of infection and to prevent possible cross-contamination. This potentially affected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The findings are: A. Observation on 2/28/23 at 7:30AM to 9:00AM, Staff H put on disposable gloves to apply shampoo to a wash cloth to apply to the eyelids of client #1. After the medications were passed, Staff H remained in the gloves and wore them outside of the medication room for the next 90 minutes, going in and out the side door.	W 454		

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 _____	02/28/2023

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W 454	Continued From page 14 B. Observation on 2/28/23 at 8:30AM, Staff B did not put on disposable gloves before administering eye drops and nose drops to client #4. Review on 2/28/23 of the facility's medication administration January 2023 training guidebook revealed: Clean gloves are used in medication administration when applying eye ointment or drops, topical medication to skin, or rectal medications, and every time you come in contact with blood or body secretions. Gloves should be removed immediately when you finish a task and hands should once again be washed. Interview on 2/28/23 with the nurse revealed that staff are trained that gloves should be one when having skin contact with clients or applying topical creams, sprays or drops. The nurse stated that gloves should come off after the task or after a contaminated procedure.	W 454		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 1 of 6 audit clients (#3) received his specially prescribed diet as indicated. The findings is: Observations on 2/27/23 at 6:45PM revealed Staff C feeding client #3 sherbet for dessert. No complications were noted.	W 460		

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 _____	02/28/2023

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W 460	Continued From page 15 Review on 2/27/23 of client #3's diet orders revealed he was to receive a heart healthy pureed diet with nectar thick liquids. Review on 2/28/23 of client #3's Speech Language Pathology Forms dated 1/20/21 revealed a diagnosis of dysphagia; aspirations precautions needed. Interview on 2/28/23 with the nurse revealed if a client is on a pureed diet due to an aspiration risk, the client should not receive ice cream or sherbet, since it melts.	W 460		