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 01/27/2023

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
W 000	INITIAL COMMENTS A revisit was conducted on 1/27/23 for all previous deficiencies cited on 11/22/22. The following deficiencies were corrected: (W153) and (W156).The facility remained out of compliance in (W508). A complaint investigation was conducted on 1/27/23 for intakes #NC00197143 and #NC00197150. Additional deficiencies were cited.	W 000		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff received annual abuse policy training. This had the potential to affect all clients (#1, #2 #3, #4, #5 and #6). The finding is: Review on 1/27/23 of an incident report dated 1/12/23 accused Staff B of causing injuries to client #4. The report noted Staff B had received training on the following dates: 6/29/22, 7/28/22, 8/27/22, 9/9/22 and 10/18/22. On 1/20/23, the facility concluded their investigation and noted Staff B abuse training for 2022 had expired and was overdue. The allegation of physical abuse was substantiated against Staff B. Interview on 1/27/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that Staff B was hired on 12/21/21. The QIDP stated Staff B was supposed to attend in-services on abuse that were conducted on 11/21/22 and 11/29/22 but he was on medical leave. The QIDP stated Staff B returned to work on 12/19/22 but	W 149	All staff will complete annual trainings according to CBC-CI policy. Admin support team members will be forwarding to the Program Manager a weekly list of staff coming up for training needs to ensure staff training compliance. QM will complete quarterly random employee chart audits to ensure staff compliance with annual training requirements. Monitoring will occur on an ongoing basis. DHSR - Mental Health FEB 27 2023 Lic. & Cert. Section	

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

Durga Hodge MA QM Director 2/20/2023

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 149	Continued From page 1 he was not required to complete his annual abuse training. The QIDP acknowledged Staff B was placed back on the schedule, to work with clients. The QIDP stated Staff B was suspended for allegations of abuse on 1/12/23 and was terminated on 1/23/23 after they substantiated abuse against client #4. Interview on 1/27/23 with the Director of the Individuals with Intellectual Disabilities (IID) program revealed no explanation for staff lacking sufficient abuse training.	W 149		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct a thorough investigation of one allegation of abuse. This affected of 1 of 1 audit clients (#4). The finding is: Review on 1/27/23 of an incident report, dated 1/12/23 with the allegation of staff to client physical abuse, revealed one of two written statements from staff who were on duty at the time of the incident. Further review indicated there were no recorded statements from verbal clients or body audits to rule out abuse of non-verbal clients. The incident described Staff B whooping client #4 with a belt, causing red marks to his neck, ear, upper torso and left arm. After the incident was investigation, the facility substantiated the allegation for physical abuse and terminated the employment of Staff B on 1/23/23.	W 154	QM will interview all verbal residents, including those residents not involved in the initial allegation, to determine their knowledge of said allegation, etc within a residential setting. Group home staff will perform body checks, in allegations of physical abuse of non-verbal residents, who were not involved in the initial allegation, to ensure there are no unexplained, bruising, marks, etc. All staff on duty at the time of the alleged incident will be interviewed by QM regarding their knowledge of the allegation. Should a staff member on duty not be available, the investigation will proceed. Once the staff member becomes available, the staff member will also be interviewed to ensure their input into the investigation. The interviewing of all verbal residents and staff on duty at the time of the alleged allegation will begin effective immediately. Group home staff will perform body checks on non-verbal residents when an allegation of abuse arises effective immediately.	

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W 154	Continued From page 2 Review on 1/27/23 of the Nurse's Exam of client #4 on 1/13/23 revealed the following injuries: 1 1/4" x 1/8" red mark right shoulder 2 1/8" x 1/4" red area upper right shoulder 8" x 1 3/8" bruise behind left ear to base of neck 4" x 1" bruise left upper arm 1 1/8" thin red line on right back 2" x 1" bruise on left forearm Interview on 1/27/23 with the Director of Quality Management (DQM), who conducted the investigation revealed she had noted that she wanted to interview Staff C who worked on 1/12/23 but did not recall why she overlooked speaking to her. The DQM acknowledged she did not attempt to speak with other verbal clients who may have witnessed the incident. The DQM also did not try to determine if there were other possible clients who may have been subjected to physical abuse, by reviewing their skin conditions, to rule out injuries of unknown origin.	W 154	In addition, the ICF Consultant will complete an inservice addressing processes for handling allegations of abuse by a staff member. QM, the Director, and CSs will participate in the training. The training will be completed by 04/26/2023. The Compliance Officer will monitor investigation processes to ensure all steps and avenues are thoroughly investigated. Monitoring will occur on an ongoing basis.	