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 07/30/2024

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 follow up and complaint survey was conducted on July 30, 2024 for intake # NC00218961 and #NC00218967 The allegations were substantiated and no deficiencies were cited for the complaint. However, there were some recited deficiencies as a result of the follow up.	W 000		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure data relative to the accomplishment of objective criteria was documented in measurable terms. This affected 2 of 6 audit clients (#1 and #4). The findings are: A. Review on 5/14/24 of client #4's Individual Program Plan (IPP) dated 11/10/23 revealed formal training programs for shopping skills once weekly at the day program, cleaning glass door 7 days per week at the home, identifying behavior medications 7 days per week at the home and coin identification 5 days per week at the day program. Review on 5/15/24 of client #4's program plan data sheets for April 2024 and May 2024 of goals that are run in the home revealed 15 days of data missing for cleaning the glass door and	W 252		

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.

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 07/30/2024

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 252	Continued From page 1	W 252		

identifying behavior medications for April 2024 and 8 days of data missing for cleaning the glass door and identifying behavior medication in May 2024.

B. Review on 5/14/24 of client #1's IPP dated 7/25/23 revealed formal training programs for toothbrushing, training 7 days a week, shopping skills training every Friday during 1st shift, eating skills, training 7 days a week, community living skills, training anytime it presents itself or as an evening activity, and exercise training 1st Monday-Friday.

Review on 5/15/24 of client #1's program plan data sheets for April 2024 and May 2024 of goals that are run in the home revealed 16 days of data missing for toothbrushing, and 30 days of missing data for shopping skills, eating skills, community living skills and exercise training. For the month of May 2024, no data collected for any training goals.

Interview on 5/15/24 the habilitation specialist revealed she had been out of work and will be working on revising and in-servicing staff on documentation on goals.

A follow up was conducted on 7/30/24 revealed:

Review on 7/30/24 of the facility's Plan of Corrections (POC) dated 7/12/24 Habilitation specialist will inservice staff regarding resident's goals, specifically reviewing the goals and documentation/data collection of clients #1 and #4. Goals to be reviewed for clients #1 will include training programs for toothbrushing, shopping skills, eating skills, community living skills, and exercising and when and how these skills should

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 07/30/2024

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 252	Continued From page 2 be addressed. Goals for client #4 will include cleaning the glass door, identifying behavior medications, and coin identification and when and how these skills should be addressed. An interview on 7/30/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that the facility had not completed the documentation for this citation. Therefore, the facility remains out of compliance.	W 252		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior techniques for 2 of 6 audit clients (#1 and #4) were reviewed and monitored by the human rights committee (HRC). The findings are: A. Review on 5/14/24 of client #4's Behavior Support Plan (BSP) dated 8/6/23 revealed target behaviors consisting of aggression, severe disruptive behavior, property destruction, inappropriate sexual behavior, taking food, stealing, failure to make responsible choices, AWOL and self-injurious behavior. Further review on 5/14/24 of client #4's BSP revealed no written consent by the HRC for the medication Buspar that was added on 11/20/23. Interview with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that client #4 did	W 262		

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 07/30/2024

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 262	Continued From page 3 not have written consent by HRC for the medication Buspar and that she was unaware the medication had been added. B. Review on 5/14/24 of client #1's BSP dated 8/26/23 revealed target behaviors consisting of hallucinating/confusing thoughts, agitation, anxious behavior, severe disruptive behavior and failure to make responsible choices. Further review on 5/14/24 of client #1's BSP no written consent by the HRC. Interview on 5/15/24 with the QIDP confirmed that client #7 did not have written consent for the HRC she only received a verbal consent. A follow up was conducted on 7/30/24 revealed: Review on 7/30/24 of the facility's Plan of Corrections (POC) dated 7/12/24 Qualified Intellectual Disabilities Professional (QIDP) will ensure that clients who have been prescribed in the situation for client #4 including psychotropic medications to address targeted behaviors, have been reviewed and written consent provided by the HRC prior to implementation. An interview on 7/30/24 with the QIDP revealed that the facility had not obtained HRC consent. Therefore, the facility remains out of compliance.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) 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 observations, record review and	W 263		

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 07/30/2024

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 263	Continued From page 4	W 263		

interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 6 audit clients (#1 and #4). The findings are:

A. Review on 5/14/24 of client #4's Behavior Support Plan (BSP) dated 8/6/23 revealed target behaviors consisting of aggression, severe disruptive behavior, property destruction, inappropriate sexual behavior, taking food, stealing, failure to make responsible choices, AWOL and self-injurious behavior. Record review on 5/14/24 of client #4's physician's orders dated 2/21/24 revealed orders for Depakote, Clonazepam, Geodon, Seroquel and Buspar.

Further record review on 5/14/24 revealed no written informed consent by the legal guardian for the use of Buspar. Interview with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that client #4 did not have written consent by the legal guardian for the medication Buspar and that she was unaware the medication had been added.

B. Review on 5/14/24 of client #1's BSP dated 8/26/23 revealed target behaviors consisting of, hallucinating/confusing thoughts, agitation, anxious behavior, severe disruptive behavior and failure to make responsible choices. Further review on 5/14/24 of client #1's BSP no written consent by a legal guardian. Interview on 5/15/24 with the QIDP confirmed that client #7 did not have written consent for the BSP she only received verbal consent.

A follow up was conducted on 7/30/24 revealed:

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 07/30/2024

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 263	Continued From page 5 Review on 7/30/24 of the facility's Plan of Corrections (POC) dated 7/12/24 Qualified Intellectual Disabilities Professional (QIDP) will ensure that clients who have been prescribed in the situation for client #4 including psychotropic medications to address targeted behaviors, have been reviewed and written consent provided by the HRC prior to implementation. An interview on 7/30/24 with the QIDP revealed that the facility had not obtained written guardian consent. Therefore, the facility remains out of compliance.	W 263		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observations, records review and interviews, the facility failed to provide nursing services in accordance with the needs of 1 of 6 audit clients (#6) relative to assuring that physician's orders were documented. The finding is: A. During observations in the home throughout the survey on 5/14/24 through 5/15/24, client #6 was observed to only consume clear liquids. Interview on 5/14/24 with the home manager revealed that client #6 was on clear liquids due to bowel prep instructions for a colonoscopy scheduled on 5/16/24. Record review of bowel prep instructions dated 4/17/24 for client #6 revealed the client could only consume clear liquids on 4/17/24 for a colonoscopy scheduled on 4/18/24.	W 331		

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 07/30/2024

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 331	Continued From page 6 Interview with the facilty nurse revealed that client #6 was scheduled for a colonoscopy on 4/18/24. However, upon arrival, the procedure was unable to be completed because the client had not cleared out his bowels. The nurse stated that this time the facility was doing 2 days of clear liquids prior to the colonoscopy to ensure client #6 was cleaned out. The nurse revealed that she did not have any documentation or physician orders to show that this was the recommendation made by the doctor. B. Review on 5/15/24 of client #1's individual program plan dated 7/25/23 revealed a diagnosis of a history of sleep apnea. Further review of nurses note dated 9/20/23 revealed a history of sleep apnea. Interview on 5/15/24 with the Registered Nurse (RN) confirmed client #1 has a diagnosis of sleep apnea history. There has been no sleep study completed while client #1 has been at the current facility. RN confirmed a sleep study needed to be completed. A follow up was conducted on 7/30/24 revealed: Review on 7/30/24 of the facility's Plan of Correction (POC) dated 7/12/24 revealed all written physician orders are obtained. the nurse will obtain a sleep study and schedule accordingly. A checklist will be developed identifying the needs of both nursing and clinical topics to ensure and assist in identifying all medical, behavioral, etc. needs a new referral might have within the initial 30 days of admission. The development of the checklists will include input from nursing and clinical staff, along with	W 331		

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 07/30/2024

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 331	Continued From page 7	W 331		

the assistance of quality management.

An interview on 7/30/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that the facility had not completed the POC. Therefore, the facility remains out of compliance.

W 369 DRUG ADMINISTRATION — W 369

CFR(s): 483.460(k)(2)

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

This STANDARD is not met as evidenced by:

Based on observations, record review and interview, the facility failed to ensure all medications were administered without error. This affected 1 of 6 clients (#4) observed receiving medications. The findings are:

During observations in the home on 5/15/24 at 7:35am, clients were observed eating breakfast. Further observations in the home at 8:37am, the home manager was observed assisting client #4 with administering his medications, which included Metformin ER 500mg and Synthroid 50mcg.

Review on 5/15/24 of client #4's physician's orders dated 2/21/24 revealed an order for Metformin ER 500mg take 1 tablet by mouth, twice daily before meals and was ordered for 7:00am and 6:00pm and Synthroid 50mcg, take 1 tablet every morning and was ordered for 7:00am.

Interview on 5/15/24 with the facility nurse revealed the facility's medication policy states

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 07/30/2024

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 369	Continued From page 8 medications can be given one hour before or one hour after scheduled medication time. The facility nurse also confirmed that client #4 received medication outside the approved time frame. The nurse also confirmed client #4 should have received Metformin before eating breakfast. A follow up was conducted on 7/30/24 revealed: Review on 7/30/24 of the facility's Plan of Correction (POC) dated 7/12/24 revealed nurse's will inservice staff to ensure staff are administering medication as ordered. The Program Manager and nurse will conduct random daily MAR checks to ensure compliance. An interview on7/30/24 with the Regional Director revealed that the facility had not completed the POC. Therefore, the facility remains out of compliance.	W 369		
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 review and interviews, the facility failed to ensure 3 of 6 audit clients (#3, #4 and #5) received their specially prescribed diet as indicated. The findings are: A. During observations in the home on 5/14/24 at approximately 3:45pm, client #4 sat down at the table for snack. Client #4 received chocolate pudding. At 5:16pm, client #4 sat down at the	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 ______	C 07/30/2024

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 460	Continued From page 9	W 460		

Continued From page 9

table for dinner. Client #4 received 1 piece of baked chicken, 1 serving of peas and carrots mixed and 1 serving of rice.

Further observations in the home on 5/15/24 at 7:35am, client #4 sat down at the table for breakfast. Client #4 received 2 waffles with sugar free syrup and one serving of eggs. Interview on 5/15/24 with the home manager revealed that client #4's diet is low concentrated sweets with sugar free jello, peanut butter and jelly sandwich for snack twice daily and double portions.

Record review of client #4's nutritional evaluation dated 10/17/23 revealed a diet of regular, heart healthy, low concentrated sweets, double portions at all meals, 1 peanut butter and jelly sandwich for snack twice daily, may have sugar free jello, pudding or low fat yogurt, Ensure Clear twice daily and no corn, tomatoes or chocolate.

Interview on 5/15/24 with the facility's nurse revealed client #4 should have received double portions at dinner and breakfast and should not have had chocolate pudding for snack.

B. During observations in the home on 5/15/24 at 7:35am, client #3 was served waffles and eggs. The consistency of the waffles was ground and eggs were the consistency of scrambled with a runny liquid.

Interview on 5/15/24 with staff B revealed she mixed some milk in with the waffles and eggs to make it smooth but it didn't work. Staff B revealed the consistency should look like baby food but the waffle or eggs were not smooth like baby food. Interview on 5/15/24 with the home manager revealed client #3 diet is pureed and his food,

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 07/30/2024

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 460	Continued From page 10 should be smooth consistency. C. During observations in the home on 5/14/24 at 5:15pm, client #5 was at the table for dinner. Client #5 received baked chicken, peas and carrots and rice. Client #5 attempted to cut baked chicken with skin on with his knife. Client #5 chicken was a shredded consistency and not a bite size. Further observation in the home on 5/15 at 7:30am client #5 was at the table for breakfast. Client #5 received 2 waffles and eggs for breakfast. Client #5 cut the waffles with a knife into long slim pieces. Interview on 5/15/24 with staff C revealed client #5 was on a bite size diet. Staff C revealed as long as client #5 cut his food up it would be bite size. Review on 5/15/24 on client #5's nutritional evaluation dated 4/15/24 revealed diet as heart healthy regular diet in bite size pieces. A follow up was conducted on 7/30/24 revealed: Review on 7/30/24 of the facility's Plan of Correction (POC) dated 7/12/24 revealed Program Manager will monitor weekly for compliance of orders. The Qualified Intellectual Disabilities Professional (QIDP) will monitor monthly. Further review on 7/30/24 client #4 had a diet change in the month of June 2024. Interview on 7/30/24 the facility nurse revealed client #4 had a diet change in June however she was unable to find the documentation to show the diet changed or documentation that the staff have been inservice on the diet change. Interview on 7/30/24 staff A revealed client #4 was on a puree diet and nectar thick liquids. She	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 ______	C 07/30/2024

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 460	Continued From page 11 was inserviced this morning of client #4 new diet puree and pudding thick liquids by her program manager. She was unaware of this diet had started in June 2024. An interview on 7/30/24 with QIDP and the Nurse revealed that the facility and staff had not been trained. Therefore, the facility remains out of compliance.	W 460		