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 12/07/2023

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 complaint survey was completed on December 7, 2023 for Intakes #NC00210323 and Intake #NC00210354. The complaint allegations were substantiated and it was determined by the team on site that an immediate jeopardy was present to the clients. The interdisciplinary team was able to develop a comprehensive plan to remove the jeopardy to the clients which was accepted by the survey team before their exit from the facility.	W 000	W122 The facility has taken the necessary steps through policy review, policy update, paraprofessional staff training, QA Specialist training, reporting requirements, thoroughness of investigations to ensure statutory mandates for client protections. 1. See the plan of protection, implemented and approved by state survey agency on 12/7/23 as follows-	1/20/2024
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients Therefore the facility must: This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibited neglect (W149) and failed to complete a thorough internal investigation that considered all sources of evidence (W154). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients.	W 122	CI Corbell Plan of Protection 120723 On November 21, 2023, while [redacted] DSP/Staff traveling back to the group home from taking a client home in Goldsboro had a single vehicle accident approximately 10-15 miles from the group home. Staff stated that the tire went on the grass and the van began to pull off the road causing the van to flip over. The two clients, [redacted] and [redacted] were taken to the emergency department by ambulance. Staff chose not to receive medical treatment. [redacted] DSP called the assistant manager of the group home.	
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 observations, reviews and interview, the facility neglected to ensure the safety of 6 of 6 clients (#1, #2, #3, #4, #5 and #6) while they were being transported in the van by staff. The finding is:	W 149	Initial investigation found that it did not appear that Staff [redacted] was neglectful of the two individuals in the van on November 21 when returning from Goldsboro. There were discrepancies from the police report and the CBC Global Positioning System at the time of the accident.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
MA	QM Director	12/20/2023

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.

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 12/07/2023

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 complaint survey was completed on December 7, 2023 for Intakes #NC00210323 and Intake #NC00210354. The complaint allegations were substantiated and it was determined by the team on site that an immediate jeopardy was present to the clients. The interdisciplinary team was able to develop a comprehensive plan to remove the jeopardy to the clients which was accepted by the survey team before their exit from the facility.	W 000	W122 The facility has taken the necessary steps through policy review, policy update, paraprofessional staff training, QA Specialist training, reporting requirements, thoroughness of investigations to ensure statutory mandates for client protections. 1. See the plan of protection, implemented and approved by state survey agency on 12/7/23 as follows-	1/20/2024
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibited neglect (W149) and failed to complete a thorough internal investigation that considered all sources of evidence (W154). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients.	W 122	CI Corbell Plan of Protection 120723 On November 21, 2023, while [redacted] DSP/Staff traveling back to the group home from taking a client home in Goldsboro had a single vehicle accident approximately 10-15 miles from the group home. Staff stated that the tire went on the grass and the van began to pull off the road causing the van to flip over. The two clients, [redacted] and [redacted] were taken to the emergency department by ambulance. Staff chose not to receive medical treatment. [redacted]/DSP called the assistant manager of the group home.	
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 observations, reviews and interview, the facility neglected to ensure the safety of 6 of 6 clients (#1, #2, #3, #4, #5 and #6) while they were being transported in the van by staff. The finding is:	W 149	Initial investigation found that it did not appear that Staff [redacted] was neglectful of the two individuals in the van on November 21 when returning from Goldsboro. There were discrepancies from the police report and the CBC Global Positioning System at the time of the accident.	

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

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 12/07/2023

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 149	Continued From page 1 Review on 12/7/23 of the facility's internal investigation and an accident report by the NC Highway Patrol indicated at around 3:00pm on 11/21/23, staff A was traveling in a facility van transporting clients #1 and #4 back to the facility in the rain after transporting client #2 for a home visit. Further review of the internal investigation dated 11/22/23 revealed staff A lost control of the van and it overturned about 10 miles from the facility. Client #1 was sitting in the front seat and client #4 was sitting in the back seat. The van rolled back onto 4 wheels in the median near the guide wire in the opposite direction of the highway. A bystander called for assistance and the NC Highway Patrol responded quickly. Clients #1 and #4 were taken by ambulance to the local hospital. Staff A refused to be transported and was picked up by another staff working at the facility. Both clients were treated at the hospital. Client #1 was not injured but client #4 sustained a gash above his right eyebrow that was treated with a liquid bandage and did not require sutures. Both clients were discharged from the hospital and returned to the home around 5:30pm after another staff picked them up from the hospital in a facility van. Staff A clocked out of work around 4:30pm. The acting home supervisor, the qualified intellectual disabilities professional (QIDP), as well as the Corporate Vice President were all notified of the accident. Staff A returned to work on 11/22/23 and it was decided by the management team to do an internal investigation on 11/22/23. Additional review revealed staff A was suspended at 1:30pm on 11/22/23 until more information could be investigated about the accident. Additional review on 12/7/23 of the facility's	W 149	(continued W122) DHSR facility surveyor arrived onsite on 12/7/23 to conduct an investigation and discovered additional findings. Based on these findings, the following measures will be enacted immediately. Training needs: Mandatory training for all Corbell staff will be provided on driving policy, incident reporting policy, cell phone policy, and core values of integrity by [redacted] Clinical Supervisor on the afternoon of 12/7/23. Training will specify that drivers must obtain manager approval for any unassigned individuals. All Corbell staff will be required to retake defensive driving by January 15th, 2024. Safeguards regarding the individuals: In light of discovery of additional findings, the investigation has been re-opened and the staff has been suspended again. Corbell members and staff members will be re-interviewed regarding circumstances of the event. A comparison of discrepancies between the police report and the CBC GPS system will be re-evaluated. Investigation process The following investigation elements will be retrained to all QA Specialists certified to conduct investigations by January 15th, 2024: Organizing the Investigation Observe, review the scene at the time of arrival Interview the person making the report Collect physical evidence	

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 12/07/2023

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 149	Continued From page 2 internal investigation concluded on 11/30/23 revealed the facility did not substantiate neglect by staff A involving the traffic accident that occurred on 11/21/23. The following recommendations were made: - It is recommended that leadership consult with their HRBP (human resources) for a coaching for staff A in regards to abiding to state driving laws. -It is recommended that when reporting allegations to follow protocol and call the Quality Management Director and not send the notification by email. - It is recommended that clinical staff review the agency policy of reporting vehicle concerns to ensure the van is always in proper working order. - It is recommended that CBC review the driving policy and consider repercussions to habitual driving infractions to include exceeding posted speed limits as identified by the CBC global positioning system. -It is recommended that leadership ensure the timeliness submission of requested information by QM in order to conduct investigations timely. -It is recommended that leadership offer EOP (employee assistance program) to staff A should he experience a need. -It is recommended that leadership consider options for the individuals to participate in therapy as it relates to this accident should it be needed. Review on 12/7/23 of the facility's policy updated on 9/23/20 under Neglect revealed, "Any situation in which the caretaker does not provide care or services which in turn affect mental or physical health, safety, or well-being of a person. Neglect further refers to the failure of the caretaker to act spontaneously in any situation which might adversely affect the health, safety or well being of	W 149	(Continued W122) Create demonstrative evidence if unable to preserve the physical evidence (e.g., diagrams, photos) Interview the victim Interview the other direct evidence (eyewitnesses) Interview the circumstantial evidence witnesses Interview the alleged target of the investigation Collect documentary evidence for review later The QA Specialists will be provided direct oversight to ensure we are meeting the investigation elements by QM Directors regarding any investigations conducted from present to time of training. Reviewed and approved by [redacted] Authorized signature: _____ [redacted] Clinical Supervisor / Date 2. Staff A was suspended on 12/7/23 and the internal investigation into the event of 11/21/23 was re-opened. At the conclusion of this investigation, neglect was substantiated. 3. All staff assigned will be in-service on safe driving techniques, and abuse. neglect prevention per facility policy. All staff will additionally be in-service on the facility policy and protocol for reporting significant	

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 12/07/2023

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 149	Continued From page 3 a person." Review on 12/7/23 of the facility's driving policy dated June 2023 revealed, "the following examples of violations may result in the staff, provider or applicant being ineligible to drive a vehicle on behalf of CBC: - 10+ mph over the speed limit in the past 5 years." Review on 12/7/23 of the accident report by the NC Highway Patrol dated 11/21/23 at 3:05pm revealed staff A was listed as the driver of the van in the accident. The local emergency services from the local fire department was listed as responding to the accident. Both clients #1 and #4 are listed on the accident report. The narrative indicates, "Vehicle 1 was traveling west on highway 74. Vehicle 1 ran off the roadway to the left, overturned and struck median cable barrier after impact, vehicle 1 came to rest roadside facing south." Further review of the accident report revealed the officer estimated the driver was driving 60 miles an hour in a work zone that is marked as 55 miles an hour. Additional review under charges listed: " Exceeding safe speed for conditions." Additional review of the accident report revealed the facility van traveled 56 feet after leaving the road surface. Review on 12/7/23 of the discharge summary from the local hospital dated 11/21/23 for client #4 revealed several scans were completed which included a CAT (computed tomography scan) scan was completed which resulted in the following assessment or plan: -Laceration of face (right eyebrow) -CHI (closed head injury) -orders:	W 149	(Continued W122) events to include but not limited to vehicle accidents that impact the health, safety and well-being of clients. 4. QA Specialists will be in-service on strategies, investigative protocols relative to a thorough and complete investigation to include but not limited to securing appropriate evidence, documents, interviews; review of information, resolving any discrepancies to ensure client protections and appropriate determination of findings and outcomes. 5.The QIDP and Program Managers will provide oversight of vehicle monitoring devices to ensure safe operation of vehicles and that staff drive in compliance with traffic laws. 6. The QM Directors and QA Consultant will review any such incidents immediately to ensure continued compliance and the necessary mandates for ongoing client protection.	

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 12/07/2023

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 149	Continued From page 4 -Cephalexin 500 mg capsule, oral every 12 hours for 5 days - Follow up with primary Physician within 2-4 days. Observation on 12/7/23 of the area at 4:15pm where the accident occurred on 11/21/23 revealed there is ongoing road construction along highway 74 East and West and that the Department of Transportation (DOT) has these areas clearly marked reducing the speed of vehicles traveling in these areas to 55 miles an hour because these are designated work zones. This reduced speed is also noted on the accident report. Interview on 12/7/23 with client #1 revealed, he was riding in the front seat of the van on 11/21/23 at the time of the accident. He confirmed he was wearing his seatbelt. Client #1 also revealed staff A was talking on his cell phone while he was driving the van, it was raining and staff A was also driving fast. Interview on 12/7/23 with client #4 revealed he was sitting in the back seat of the van and did not know what happened on 11/21/23. He indicated that the radio was on and that he fell and hit his eye. Client #4 pointed to the gash over his right eye, which was still healing. Interview on 12/7/23 with the qualified intellectual disabilities professional (QIDP) revealed she was told about the accident on 11/21/23 involving staff A, clients #1 and #4 and that she went to the accident scene and to the hospital to check on staff and clients. The QIDP stated it had been raining hard that afternoon in the location around the facility. Further interview revealed she found	W 149	W149 The facility will implement policies and procedures to ensure the safety of clients during transport by staff such that they are not neglected as a result of unsafe driving. 1. Staff A was suspended on 12/7/23 and the investigation was re-opened. The police report was secured which contained pertinent details of the accident. Staff A received a citation for excessive speeding. As a result of the investigation neglect was substantiated. 2. All staff assigned will be in-service on safe driving techniques, and abuse. neglect prevention per facility policy. All staff will additionally be in-service on the facility policy and protocol for reporting significant events to include but not limited to vehicle accidents that impact the health, safety and well-being of clients. 3.All staff will receive updated training on safe vehicle operations in accordance with facility policy. 4.Staff training will be provided on the reporting protocol for events that result in potential acts that impact the health, safety and well-being of clients to include but not limited to vehicle accidents. 5.The QIDP and Program Managers will provide oversight to ensure the safe operation of vehicles and direct staff who transport clients to drive in compliance with traffic laws.	1/20/2024

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 12/07/2023

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 149	Continued From page 5 out at the accident scene that both clients #4 and #1 were in the van, The QIDP stated staff A had not cleared taking 2 additional clients to transport client #2 for a home visit. The QIDP stated staff A finished his shift, picked up his car at the facility and clocked out at 4:30pm on 11/21/23. Additional interview revealed the corporate management team made a decision to start an internal investigation into the accident on 11/22/23 and the decision was made to suspend staff A at 1:30pm until more information could be obtained about the circumstances involving the accident. Additional interview with the QIDP revealed corporate personnel had interviewed staff A, reviewed the accident report and made the decision to return staff A to work on December 1, 2023. When asked if the facility had made decisions regarding staff A transporting the clients, the QIDP stated, " He will absolutely not be transporting the clients." When asked how management was going to monitor staff A's driving, she stated," I am the QIDP and I will make certain he is not driving." Interview on 12/7/23 with the direct care supervisor A revealed staff A was working in the facility on 12/7/23 transporting clients to physician appointments in the area and we would not be able to interview him until later in the afternoon. When asked if there were any restrictions to staff A transporting clients she stated, "No, not that I am aware of." Interview on 12/7/23 with direct care supervisor B revealed she was acting supervisor on 11/21/23 because supervisor A was out of work. Supervisor B stated that staff A made the decision on 11/21/23 without consulting her to take 2 additional clients (#1 and #4) in the facility van to	W 149		

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 12/07/2023

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 149	Continued From page 6 transport client #2 for a home visit in Goldsboro. Direct care supervisor B stated she was made aware at the time of the accident that both clients #1 and #4 were in the van. Additional interview revealed she had reported this to the QIDP and the QM Specialist. Interview on 12/7/23 with the quality management (QM) specialist revealed she had interviewed staff A and asked him after the accident if he had received a traffic citation as a result of the accident. The QM stated that staff A told her he had not received a traffic citation as a result of the accident. Further interview revealed Corporate Management had made the decision to install global positioning devices (GPS) on the facility vans. She stated she was asked to pull the GPS data for the facility van on 11/21/23 for the times surrounding the vehicle accident on 11/21/23. The GPS data revealed the following: 11/21/23 at 2:52pm: 80 miles an hour 11/21/23 at 2:52pm: 84 miles an hour 11/21/23 at 2:54pm: 71 miles an hour 11/21/23 at 2:55pm: 0 miles per hour Additional interview on 12/7/23 with the QM Specialist revealed this GPS data was not shared with the NC Highway Patrol and that corporate management had not reviewed this information before making a decision to bring staff A back to work because the GPS tracking devices were relatively new technology and ultimately, "They did not trust the accuracy of the data." When asked if she was aware that staff A had received a traffic citation on 11/21/23 as a result of the accident, she stated she had reviewed the accident report but did not see the notation that he had received a traffic citation for exceeding	W 149		

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 12/07/2023

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 149	Continued From page 7 safe speed. When the QM specialist was asked when the decision was made to return staff A to work, she stated corporate staff had not considered the GPS information, missed the information about the traffic citation and had returned staff A to work without any restrictions on December 1, 2023. During interview on 12/7/23 with the QIDP she stated she was aware that it was raining on 11/21/23 when the accident occurred and had expressed concerns that staff A was exceeding safe speeds going through a marked Department of Transportation work zone. Further interview revealed she was also aware that staff A had received a traffic citation for exceeding safe speed for road conditions. Additional interview confirmed staff A had returned to work after his suspension on December 1, 2023 without driving restrictions and was transporting clients on 12/7/23 to physician appointments. A situation of Immediate Jeopardy was identified by the team on site as the facility failed to identify neglect in that staff A exceeded safe speed in the operation of the facility van in adverse weather conditions, failed to communicate with his supervisor regarding clients #1 and #4 accompanying him on the outing and failed to truthfully identify the circumstances around the accident. The facility made the decision to return staff A to work without any review of his driving record and without restrictions transporting clients. The facility also failed to follow its own policies and procedures for identifying neglect and for transporting consumers in facility vans. Management of the facility was made aware of the situation of immediate jeopardy on 12/7/2 after this had been reviewed with Division of	W 149		

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 12/07/2023

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 149	Continued From page 8 Health Service Regulation (DHSR) management. Review of a Plan of Protection (POP) dated 12/7/23 developed by corporate and facility management of the facility to remove the immediate jeopardy to the clients included the following: - Mandatory immediate training for all facility staff will be provided on driving policy, incident reporting policy, cell phone policy and core values. -Staff A was suspended again on 12/7/23 and the investigation for the van accident that occurred has been re opened.. -All elements of conducting investigations will be re-evaluated which includes: organizing the investigation, Observe review the scene and time of arrival, interview the person making the report, create demonstrative evidence if unable to preserve the physical evidence, interview the victim, interview circumstantial evidence witnesses, interview the target of the investigation and collect documentary evidence for review later . -The QA specialists will be provided direct oversight to ensure we are meeting the investigation elements by QM Directors regarding any investigations conducted from present to time of training. The POP was signed by the facility QIDP dated 12/7/23. This POP was accepted by the survey team on site and the immediate jeopardy to the clients in the facility was determined to be removed effective 4:00pm on 12/7/23.	W 149		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)	W 154		

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 12/07/2023

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 154	Continued From page 9 The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an incident of neglect was thoroughly investigated and all sources of evidence were considered. This affected 2 of 6 clients (#1 and #4). The finding is: Review on 12/7/23 of the facility's internal investigation and an accident report by the NC Highway Patrol indicated at around 3:00pm on 11/21/23, staff A was traveling in a facility van transporting clients #1 and #4 back to the facility in the rain after dropping off client #2 for a home visit. Additional review of the internal investigation dated 11/22/23 revealed staff A lost control of the van and it overturned about 10 miles from the facility. Client #1 was sitting in the front seat and client #4 was sitting in the back seat. The van rolled back onto 4 wheels in the median neat to the guide wire in the opposite direction of the highway. A bystander called for assistance and the NC Highway Patrol responded quickly. Clients #1 and #4 were taken by ambulance to the local hospital. Staff A refused to be transported and was picked up by another staff working at the facility. Both clients were treated at the hospital. Client #1 was not injured but client #4 sustained a gash above his right eyebrow that was treated with a liquid bandage and did not require sutures. Both clients were discharged from the hospital and returned to the home around 5:30pm after another staff picked them up from the hospital in a facility van. Staff A clocked out of work around 4:30pm. The acting home supervisor, the qualified intellectual disabilities professional (QIDP), as well as the Corporate Vice President were all notified of the accident. Staff A returned	W 154	W154 The facility will ensure that all incidents of abuse, neglect, or potential client protection violations are thoroughly investigated. 1.The investigation was re-opened effective 12/3/23. Staff A was immediately suspended indefinitely pending the outcome of the investigation. The investigation was conducted by the QM Director and the QA Consultant. 2. As a result of the investigation completed 12/15/23, neglect was substantiated as Staff #A received a traffic violation and was traveling at excessive speeds that resulted in harm to client's #1 and #4. 3.The QM Directors and QA Consultant will provide training on investigative strategies, investigation planning, collection of evidence to ensure a thorough investigation. 4.. QA Specialist will be in-service on techniques to ensure a thorough and complete investigation to include but not limited to securing appropriate evidence, comprehensive interviews, review of findings and resolving discrepancies to ensure client protections and the appropriate determination of findings and outcomes. 5.QM Directors and QA Consultant will consult with management weekly, monitor all investigations to ensure client protection and appropriate determination of findings.	1/20/2024

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 12/07/2023

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 154	Continued From page 10 to work on 11/22/23 and it was decided by the management team to do an internal investigation on 11/22/23 and staff A was suspended at 1:30pm on 11/22/23 until more information could be investigated about the accident. Additional review on 12/7/23 of the facility's internal investigation that was concluded on 11/30/23 revealed the facility did not substantiate neglect by staff A involving the traffic accident that occurred on 11/21/23. The following recommendations were made: - It is recommended that leadership consult with their HRBP (human resources) for a coaching for staff A in regards to abiding to state driving laws. -It is recommended that when reporting allegations to follow protocol and call the Quality Management Director and not send the notification by email. - It is recommended that clinical staff review the agency policy of reporting vehicle concerns to ensure the van is always in proper working order. - It is recommended that CBC review the driving policy and consider repercussions to habitual driving infractions to include exceeding posted speed limits as identified by the CBC global positioning system. -It is recommended that leadership ensure the timeliness submission of requested information by QM in order to conduct investigations timely. -It is recommended that leadership to offer EOP(employee assistance program) assistance to staff A should he experience a need. -It is recommended that leadership consider options for the individuals to participate in therapy as it relates to this accident should it be needed. Review on 12/7/23 of the facility's policy defining	W 154		

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 12/07/2023

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 154	Continued From page 11 Neglect updated 9/23/20 revealed, "Any situation in which the caretaker does not provide care or services which in turn affect mental or physical health, safety, or well-being of a person. Neglect further refers to the failure of the caretaker to act spontaneously in any situation which might adversely affect the health, safety or well being of a person." Review on 12/7/23 of the facility's driving policy dated June 2023 revealed, "the following examples of violations may result in the staff, provider or applicant being ineligible to drive a vehicle on behalf of CBC: - 10+ mph over the speed limit in the past 5 years." Review on 12/7/23 of the accident report by the NC Highway Patrol dated 11/21/23 at 3:05pm revealed staff A was listed as the driver of the van in the accident. The local emergency services from the local fire department was listed as responding to the accident. Both clients #1 and #4 are listed on the accident report. The narrative indicates, "Vehicle 1 was traveling west on highway 74. Vehicle 1 ran off the roadway to the left, overturned and struck median cable barrier after impact, vehicle 1 came to rest roadside facing south." Further review of the accident report revealed the officer estimated the driver was driving 60 miles an hour in a work zone that is marked as 55 miles an hour. Additional review under charges listed: " Exceeding safe speed for conditions." Additional review of the accident report revealed the facility van traveled 56 feet after leaving the road surface. Review on 12/7/23 of the discharge summary from the local hospital dated 11/21/23 for client #4	W 154		

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 12/07/2023

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 154	Continued From page 12 revealed several scans were completed which included a CAT scan was completed which resulted in the following assessment or plan: -Laceration of face (right eyebrow) -CHI (closed head injury) -orders: Cephalexin 500 mg capsule, oral every 12 hours for 5 days - Follow up with primary Physician within 2-4 days. Observation on 12/7/23 of the area at 4:15pm where the accident occurred on 11/21/23 revealed there is ongoing road construction along highway 74 East and West and that the Department of Transportation (DOT) has these areas clearly marked reducing the speed of vehicles traveling in these areas to 55 miles an hour because these are designated work zones. This reduced speed is also noted on the accident report. Interview on 12/7/23 with client #1 revealed, he was riding in the front seat of the van on 11/21/23 at the time of the accident. He confirmed he was wearing his seatbelt. Client #1 also revealed staff A was talking on his cell phone while he was driving the van, it was raining and staff A was also driving fast. Interview on 12/7/23 with client #4 revealed he was in the van and did not know what happened on 11/21/23. He indicated that the radio was on and that he fell and hit his eye. Client #4 pointed to the gash over his right eye which was still healing. Interview on 12/7/23 with the qualified intellectual disabilities professional (QIDP) revealed she was	W 154		

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 12/07/2023

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 154	Continued From page 13 told about the accident on 11/21/23 involving staff A and clients #1 and #4 and that she went to the accident scene and to the hospital to check on staff A, client #1 and client #4. The QIDP stated it had been raining hard that afternoon in the location around the facility. Further interview revealed she found out at the accident scene that both clients #4 and #1 were in the van. The QIDP stated staff A had not cleared with acting direct care supervisor B taking 2 additional clients to transport client #2 for a home visit. The QIDP stated staff A finished his shift, picked up his car at the facility and clocked out at 4:30pm on 11/21/23. Additional interview revealed the corporate management team made a decision to start an internal investigation into the accident on 11/22/23 and the decision was made to suspend staff A at 1:30pm until more information could be obtained about the circumstances involving the accident. Additional interview with the QIDP revealed corporate personnel had interviewed staff A, reviewed the accident report and made the decision to return staff A to work on December 1, 2023. When asked if the facility had made decisions regarding staff A transporting the clients, the QIDP stated, "He will absolutely not be transporting the clients." When asked how management was going to monitor staff A's driving, she stated," I am the QIDP and I will make certain he is not driving." Interview on 12/7/23 with direct care supervisor B revealed she was acting supervisor on 11/21/23 because supervisor A was out of work. Supervisor B stated that staff A made the decision on 11/21/23, without consulting her, to take 2 additional clients (#1 and #4) in the facility van to transport client #2 for a home visit. Direct care supervisor B stated she was made aware at the	W 154		

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 12/07/2023

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 154	Continued From page 14 time of the accident that both clients #1 and #4 were in the van. Additional interview revealed she had reported this to the QIDP and the Quality management (QM) Specialist. Interview on 12/7/23 with the QM specialist revealed she had conducted the internal investigation into the van accident on 11/21/23. The QM specialist stated she interviewed staff A and asked him after the accident if he had received a traffic citation as a result of the accident. The QM stated that staff A told her he had not received a traffic citation. Further interview revealed corporate management had made the decision several weeks ago to install global positioning devices (GPS) on the facility vans. She stated she was asked to pull the GPS data for the facility van on 11/21/23 for the times surrounding the vehicle accident on 11/21/23. The GPS data revealed the following: 11/21/23 at 2:52pm: 80 miles an hour 11/21/23 at 2:52pm: 84 miles an hour 11/21/23 at 2:54pm: 71 miles an hour 11/21/23 at 2:55pm: 0 miles per hour Additional interview on 12/7/23 with the QM Specialist revealed this information was not shared with the NC Highway Patrol and that corporate management had not used this information before making a decision to bring staff A back to work because the GPS tracking devices were relatively new technology and ultimately, "They did not trust the accuracy of the data." When asked if she was aware that staff A had received a traffic citation on 11/21/23 as a result of the accident, she stated she had reviewed the accident report but did not see the notation that he had received a traffic citation for	W 154		

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 12/07/2023

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 154	Continued From page 15 exceeding safe speed. Continued interview on 12/7/23 with the QM Specialist confirmed management had ignored the GPS information, missed the information about the traffic citation and had returned staff A to work without any restrictions on December 1, 2023. The QM specialist stated she was unaware staff A had violated facility driving policy for company vehicles by exceeding the posted speed limit by over 10 miles per hour and that the facility had failed to identify neglect as defined by their own policy and procedures. The QM specialist also acknowledged she had failed to include in the investigation that client #4 had received medical treatment for a closed head injury although she had read the hospital discharge report. The QM specialist acknowledged when client #1 was initially interviewed he did not include any information alleging that staff A was talking on his personal cellphone prior to the accident, which also was a violation of facility policy. In that the facility failed to conduct a thorough investigation, this resulted in the facility's failure to assure the clients in the home were not neglected and subjected to further harm.	W 154		