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 _____	R 09/10/2025

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 9/10/25 for deficiencies cited on 7/7/25 - 7/8/25. All previously cited deficiencies have been corrected. However, new noncompliance was found.	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to monitor general operating direction over the facility. This affected 5 out of 5 clients (#1, #2, #3, #4, and #5). The finding is: Observation on 9/10/25 in the home from 6:20am to 8:00am revealed clients #1, #2, #3, #4, and #5 at the table eating breakfast. Staff B sat beside client #3 to assist with breakfast. Staff A stood beside the dining table to prompt other clients (#1, #2, #4, and #5). A car seat containing a small baby was placed on the kitchen counter beside the sink. During breakfast, the baby cried to be fed, and Staff A repeatedly stepped to the kitchen to tend to the baby and put the bottle in her mouth. At 7:05am, Staff A poured coffee for client #4 and stepped to the kitchen to continue feeding the baby. She then prompted client #4 to drink his juice first because the coffee was hot, as she continued to feed the baby. At 7:15am, Staff A picked the baby up and carried her to the bathroom hallway area to ensure client #4 brushed his teeth. At 7:22am, client #1 washed his dishes at the sink as the baby watched from the car seat, placed on the counter beside the sink. Staff A stood in the dining area prompting clients as they finished breakfast. At 7:30am,	W 104		

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

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W 104	Continued From page 1 Staff A went to the back hallway area to assist with personal care, leaving the baby on the kitchen counter unattended. At 7:45am, the baby began to fret and cry. Staff A took the baby to her car to leave at 8:00am, after first shift staff arrived. Interview on 9/10/25 at with Staff A revealed she was "helping family out" by watching the baby. Her daughter works 1st shift and has to be at work by 5:00am, but the daycare does not open until 6:00am. At 7:00am, Staff A stated the baby's other grandma was on the way to pick her up. Interview on 9/10/25 with Staff B revealed he was not aware of Staff A keeping the baby regularly. Interview on 9/10/25 with the Director revealed she was not aware a baby was being kept at the home. It is not allowed to bring children and family members to the home for care. The Director acknowledged staff focus should be solely on the clients in the home and children in the home could be a safety issue during an emergency situation.	W 104		