

034-016

PRINTED: 09/26/2025
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2025
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NAME OF PROVIDER OR SUPPLIER THE ATRIUM/THE RESPITE CENTER	STREET ADDRESS CITY, STATE, ZIP CODE 101 HORIZONS LANE RURAL HALL, NC 27045
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W 125	<p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the right to dignity and respect relative to providing personal care affecting 1 of 6 audited clients (#20) on the B wing. The finding is:</p> <p>Observations in the facility on 9/16/25 from 5:15PM-6:00PM revealed client #20 to be seated in the day room on the B wing with her pants soiled. Further observations revealed client #20 to have soiled herself covering from the clients' waist to her thigh area on both legs. Continued observation at 6:00PM revealed staff to place a shirt protector around client #20's neck on top of the soiled pants. At no point during the observation did staff remove client #20 from the day room to provide personal care and change her pants</p> <p>Interview with the nursing manager on 9/17/25 revealed that client #20 has a g-tube which will leak at times. Further interview with the nurse manager revealed staff should not have allowed client #20 to remain in the day room with their peers with soiled clothes for a long period of time. Continued interview verified that staff should have made nursing aware and taken client #20 to her room for personal care and putting on clean clothes.</p>	W 125	<p>In response to this deficiency, several items will be addressed to ensure that each client are exercising their rights for dignity and respect.</p> <p>The QIDP and Director of Operations will retrain all staff on protection of client rights with an emphasis on dignity and respect and privacy. Training will be documented. To ensure compliance, QIDP, DOO, DON, Unit nurse, and Team leads will conduct routine spot checks with documentation.</p> <p style="text-align: center;">RECEIVED OCT 15 2025 DHSR-MH Licensure Sect</p>	11/16/25
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE PRESIDENT & CEO	(X6) DATE 10-9-25
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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 125	Continued From page 1 Interview with the qualified intellectual disabilities professional (QIDP) on 9/17/25 revealed staff have been trained to honor the dignity and respect of the clients at all times.	W 125			
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, document review, and interview, the facility failed to ensure clients were afforded privacy during medication administration. This affected 2 of 6 audited clients (#9 and #17). The finding is. A. The facility failed to ensure privacy was given during the medication administration for client #9. Observation during the medication administration (C-Wing) on 9/17/25 revealed Med Tech #1 to prepare client #9's medication on top of the medication cart while standing in the hallway. Continued observation revealed the Med Teach #1 to transport client #9 to the hallway from the dayroom to administer his medications through his g-tube. Further observation revealed at no time did Med Tech #1 utilize a private screen or client #9's bedroom. Review on 9/17/25 of the facility's medication administration policy dated 5/23/19 revealed the following procedures " to promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medication and adhere to the "five rights" of medication administration. Residents	W 130	In response to this deficiency, several items will be addressed to ensure that clients are afforded privacy during medication administration. DON and Unit Nurse Manager will conduct an Inservice to retrain med technicians and nursing staff on client rights with emphasis on privacy and drug education. Training will be documented. To ensure compliance, 1. Staff members were counseled and reeducated. 2. Audits will be conducted by DON or nurse manager to identify any additional incidents of medication administration in hallways or other non-private areas.	11/16/25	

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W 130	<p>Continued From page 2</p> <p>should be in the most private setting allowable at the time of medication administration to allow for drug education."</p> <p>Interview with the nursing manager and the qualified intellectual disabilities professional (QIDP) on 9/17/25 revealed client #9 should have been offered privacy during his medication pass.</p> <p>B. The facility failed to ensure privacy was given during the medication administration for client #17.</p> <p>Observation during the medication administration (B-Wing) on 9/17/25 revealed Med Tech #2 to prepare client #17's medication on top of the medication cart while standing in the hallway. Continued observation revealed Med Tech #2 to administer client #17's medication through his g-tube in the hallway while staff and other residents were passing by. Further observation revealed at no time did Med Tech #2 utilize a private screen or client #17's bedroom.</p> <p>Review on 9/17/25 of the facility's medication administration policy dated 5/23/19 revealed the following procedures " to promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medication and adhere to the "five rights" of medication administration. Residents should be in the most private setting allowable at the time of medication administration to allow for drug education."</p> <p>Interview with the nursing manager and the QIDP on 9/17/25 revealed client #17 should have been offered privacy during his medication pass.</p>	W 130	<p>In response to this deficiency, several items will be addressed to ensure that clients are afforded privacy during medication administration.</p> <p>DON and Unit Nurse Manager will conduct an Inservice to retrain med technicians and nursing staff on client rights with emphasis on privacy and drug education. Training will be documented. To ensure compliance,</p> <ol style="list-style-type: none"> 1. Staff members were counseled and reeducated. 2. Audits will be conducted by DON or nurse manager to identify any additional incidents of medication administration in hallways or other non-private areas. 	11/16/25

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W 340 W 340	Continued From page 3 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, document review, and interview, the facility failed to provide nursing services in accordance with the clients' needs relative to addressing the clients' medical needs and providing drug education with the nurse/med tech for 4 of 6 audited clients (#9, #17, #20 and #24). The findings are: A. The facility failed to notify nursing of concerns with client #20's g-tube. For example: Afternoon observations in the facility on 9/16/25 from 5:15PM-6:00PM revealed client #20 to be seated in the day room on B-Wing with her pants soiled. Continued observation revealed the soiled area to cover from client #20's waist area to her thighs on both legs. Further observation revealed that at no point during the observation did staff alert nursing services to check client #20's g-tube for signs of leakage. Interview with the nursing manager on 9/17/25 revealed staff should have alerted nursing of the client's soiled pants covering from her waist to her thighs as it could have been leakage or blockage in the g-tube. Further interview with the nursing manager verified staff have been trained to alert nursing when a client's g-tube needs to be checked	W 340 W 340	In response to this deficiency, several items will be addressed to ensure all staff take measures to inform nursing services of all appropriate and preventative measures for health and hygiene methods and provide drug education DON and DOO will retrain all staff on the need to notify nursing of any resident's nursing needs, ie g-tube failure. To ensure compliance, staff members will be counseled and reeducated. DON will retrain all medication technicians and nursing staff on informing the residents of drug education. Training will be documented. To ensure compliance DON or Designee will conduct random medication pass observations weekly on all shifts for 4 weeks, then monthly random observations for 3 months.	11/16/25	

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W 340	<p>Continued From page 4</p> <p>B The facility failed to provide drug education during the medication administration for client #17.</p> <p>Observations during the medication administration(B-Wing) on 9/17/25 at 6:54 AM revealed Med Tech #2 to prepare client #17's medication on top of the medication cart while standing in the hallway with her back turned away from client #17. Continued observation revealed a staff member to transport client #17 from the hallway to the dayroom while Med Tech #2 continued to prepare the medications. Further observation revealed Med Tech #2 to transport client #17 from the dayroom back to the hallway and administered the medications through his g-tube. Additional observation revealed that at no time did Med Tech #2 inform client #17 what medications he was taking, its purpose, and by which route.</p> <p>Review on 9/17/25 of the facility's medication administration policy dated 5/23/19 revealed the following procedures "confirm the patients' identity using the information with the MAR or EMAR Explain that the medication is getting ready to be given and by which route. Each medication should be explained as to what it is and its purpose. To promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medication and adhere to the "five rights" of medication administration. Residents should be in the most private setting allowable at the time of medication administration to allow for drug education."</p> <p>Interview on 9/17/25 with the nursing manager</p>	W 340	<p>In response to this deficiency, several items will be addressed to ensure all staff take measures to inform nursing services of all appropriate and preventative measures for health and hygiene methods and provide drug education</p> <p>DON and DOO will retrain all staff on the need to notify nursing of any resident's nursing needs, ie g-tube failure. To ensure compliance, staff members will be counseled and reeducated.</p> <p>DON will retrain all medication technicians and nursing staff on informing the residents of drug education. Training will be documented. To ensure compliance DON or Designee will conduct random medication pass observations weekly on all shifts for 4 weeks, then monthly random observations for 3 months.</p>	11/16/25	

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W 340	<p>Continued From page 5</p> <p>confirmed that Med Tech #2 should have provided drug education to client #17 by stating what the medication is, its purpose, and which route.</p> <p>C. The facility failed to provide drug education during the medication administration for client #24.</p> <p>Observations during the medication administration(B-Wing) on 9/17/25 at 7:25 AM revealed Med Tech #2 to prepare client #24's medication on top of the medication cart while standing in the hallway. Continued observation revealed client #24 was in her bedroom lying in bed. Further observation revealed Med Tech #2 to enter into client #24's bedroom and administered the medications through her g-tube. Additional observation revealed that at no time did Med Tech #2 informed client #24 what medications she was taking, its purpose, and by which route.</p> <p>Review on 9/17/25 of the facility's medication administration policy dated 5/23/19 revealed the following procedures "confirm the patients' identity using the information with the MAR or EMAR. Explain that the medication is getting ready to be given and by which route. Each medication should be explained as to what it is and its purpose. To promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medication and adhere to the "five rights" of medication administration. Residents should be in the most private setting allowable at the time of medication administration to allow for drug education."</p>	W 340	<p>In response to this deficiency, several items will be addressed to ensure all staff take measures to inform nursing services of all appropriate and preventative measures for health and hygiene methods and provide drug education</p> <p>DON and DOO will retrain all staff on the need to notify nursing of any resident's nursing needs, ie g-tube failure. To ensure compliance, staff members will be counseled and reeducated.</p> <p>DON will retrain all medication technicians and nursing staff on informing the residents of drug education. Training will be documented. To ensure compliance DON or Designee will conduct random medication pass observations weekly on all shifts for 4 weeks, then monthly random observations for 3 months.</p>	11/16/25	

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W 340	<p>Continued From page 6</p> <p>Interview on 9/17/25 with the nursing manager confirmed that Med Tech #2 should have provided drug education to client #24 by stating what the medication is, its purpose, and which route.</p> <p>D. The facility failed to provide drug education during the medication administration for client #9.</p> <p>Observations during the medication administration(C-Wing) on 9/17/25 at 7:44 AM revealed Med Tech #1 to prepare client #9's medication on top of the medication cart while standing in the hallway. Continued observation revealed client #9 was participating in activities in the dayroom. Further observation revealed Med Tech #1 to transport client #9 from the dayroom to the hallway and administered the medications through his g-tube. Additional observation revealed that at no time did Med Tech #1 informed client #9 what medications he was taking, its purpose, and by which route.</p> <p>Review on 9/17/25 of the facility's medication administration policy dated 5/23/19 revealed the following procedures "confirm the patients' identity using the information with the MAR or EMAR. Explain that medications is getting ready to be given and by which route. Each medication should be explained as to what it is and its purpose. To promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medication and adhere to the "five rights" of medication administration. Residents should be in the most private setting allowable at the time of medication administration to allow for drug education."</p>	W 340	<p>In response to this deficiency, several items will be addressed to ensure all staff take measures to inform nursing services of all appropriate and preventative measures for health and hygiene methods and provide drug education</p> <p>DON and DOO will retrain all staff on the need to notify nursing of any resident's nursing needs, ie g-tube failure. To ensure compliance, staff members will be counseled and reeducated.</p> <p>DON will retrain all medication technicians and nursing staff on informing the residents of drug education. Training will be documented. To ensure compliance DON or Designee will conduct random medication pass observations weekly on all shifts for 4 weeks, then monthly random observations for 3 months.</p>	11/16/25	

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W 340	Continued From page 7 Interview on 9/17/25 with the nursing manager confirmed that Med Tech #1 should have provided drug education to client #9 by stating what the medication is, its purpose, and which route.	W 340			
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, document review, and interview, the facility failed to ensure all drugs remained locked except when being administered on the C-Wing. The findings are: A. The facility failed to ensure medications were locked when not being administered for client #17. Observations during the medication administration (B-Wing) on 9/17/25 at 6:54 AM revealed the medication technician (Med Tech) #2 to prepare client #17's medications on top of the medication cart while standing in the hallway. Continued observation revealed Med Tech #2 to walk away leaving client #17's medications in a syringe on top of the cart while transporting client #17 from the day room back to the hallway. Further observation revealed medications to be unlocked and accessible to anyone at the facility. Interview on 9/17/25 with the nursing manager confirmed the medications and drug storage should be locked before the Med Tech leaves the area during medication administration. B. The facility failed to keep topicals and	W 382	In response to this deficiency, all drug and biologicals are locked except when being prepared for administration. DON will retrain all nursing staff on the need for medications including topicals to be stored in locked compartment when not in use. Training will be documented. To ensure compliance the DON or designee will conduct random security checks of medication carts and storage areas weekly on all shifts for 4 weeks with medication locking procedures. Training will be ongoing as needed.	11/16/25	

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W 382	<p>Continued From page 8</p> <p>biologicals locked when not in use for client #21 on the D wing. For example:</p> <p>Afternoon observations in the facility on 9/16/25 from 4:30PM-6:00PM revealed several topicals with prescription labels on the nightstand in client #21's room. Further observations at 6:00PM revealed this surveyor to alert the nursing manager that the topicals have been in client #21's room for approximately 75 minutes. Continued observations revealed the nursing manager to remove the topicals from client #21's room and secure them in the medication cart.</p> <p>Interview with the nursing manager on 9/17/25 verified that topicals should be locked in the medication cart or nurses' station when they are not in use. Further interview with the nursing manager revealed staff have been trained to not allow topicals with prescription labels to remain in clients' rooms unsecured.</p> <p>C. The facility failed to keep the medication cart locked when not in use on the C wing. For example:</p> <p>Afternoon observations from 4:30PM-5:58PM revealed an unlocked medication cart in the hallway on the C-wing. Further observations at 6:00 PM revealed a surveyor to alert the qualified intellectual disabilities professional (QIDP) that the medication cart has remained unlocked for a significant period of time.</p> <p>Interview with the nursing manager and QIDP on 9/17/25 revealed med tech staff should have ensured the medication cart was secured as soon as they stepped away from the cart. Further interview with the nursing manager verified</p>	W 382	<p>In response to this deficiency, all drug and biologicals are locked except when being prepared for administration.</p> <p>DON will retrain all nursing staff on the need for medications including topicals to be stored in locked compartment when not in use. Training will be documented. To ensure compliance the DON or designee will conduct random security checks of medication carts and storage areas weekly on all shifts for 4 weeks with medication locking procedures. Training will be ongoing as needed.</p>	11/16/25

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W 382	Continued From page 9 medication technician staff have been trained to keep the medication cart double locked when it is not in use.	W 382			