STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G184	A. BUILDING _____ B. WING _____	08/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON REA DRIVE GROUP HOME	3747 BON REA DRIVE CHARLOTTE, NC 28266

(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 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 observation and interview the facility failed to assure privacy was maintained for 2 of 6 clients (#3 and #4). The findings are: A. Observation on 8/7/18 at 7:55 AM revealed staff to assist client #3 into his room. Staff was observed to ask client #3 if the client would change his shirt in preparing the client to leave for the day program. Additional observation revealed staff to assist client #3 with changing his shirt while leaving his bedroom door open visible for anyone, including this surveyor to observe the client while changing. B. Observation on 8/7/18 at 7:58 AM revealed staff to assist client #4 with entering his room and prompting the client with the need to change his pants before leaving for the day placement program. Staff was further observed to leave the bedroom door of client #4 open while changing the client's pants, allowing the client to be visible to all including this surveyor while changing the client's pants. Interview with the facility qualified intellectual disabilities professional (QIDP) revealed staff should have closed the bedroom doors of clients #3 and #4 while assisting each client with changing clothing. Further interview with the QIDP verified staff are provided privacy training relative to client rights to privacy when each staff	W 130		
		W130	W130-In order to ensure the rights and privacy of all clients,staff will receive on privacy and protection of client rights. This training will be conducted by the Group Home Manager by October 7, 2018. This training included but was not limited to closing doors for privacy when assisting individuals with dressing and other personal care activities. Additionally, a privacy guide sheet will be added to the clients program/working books as a reminder to staff to honor the individuals privacy rights at all times. This page will also be reviewed as part of the privacy training. This procedure will be implemented by October 7, 2018.	10/7/18

DHSR NH L&C Black Mountain WRO Received AUG 20 2018 by: SKH

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

Juliey B, BSW, QP Compliance Specialist 8/17/18

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 130	Continued From page 1 is hired and staff could benefit from additional training due to survey observations.	W 130		
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 observation, review of the records, and staff interview, nursing services failed to address medical recommendations for 1 of 6 clients (#2) relative to a gait belt. The finding is: Observation throughout the 8/6-7/18 survey revealed client #2 to wear a gait belt and be assisted by staff with ambulation with staff holding loops attached to the back of the client's gait belt. Observation in the group home on 8/7/18 at 7:00 AM revealed this surveyor to be in the facility medication room observing a medication pass for client #3. During the observation, staff entered the medication room and informed this surveyor that client #2 had fallen and nursing had directed the client be taken to the emergency room for medical evaluation due to a abrasion to the head as a result of the fall. Interview with staff revealed client #2 to have multiple falls over the past few months. Observation of client #2 before transport to the hospital for medical treatment revealed the client to seem oriented, aware of injury by pointing to his head and with calm demeanor. Review of client #2's record on 8/7/18 revealed a neurology consult on 7/25/17 with a recommendation: gait belt needed for safety. A	W 331	W331- In an effort to ensure recommendations for client # 2 relative to a gait belt are being followed, LIFESPAN has received and implemented a gait belt client #2. The Physical Therapist will conduct an in-service with Group Home and Day Program staff on proper use of the gait belt with client #2. This training will be conducted by October 7, 2018. In an effort to ensure that all medical recommendations are being followed, the Group Home Manager will scan the medical consults to the nursing staff as soon as possible after an appointment in the case that the nursing staff does not attend the appointment. Nursing staff will then review the medical consult including all recommendations to ensure that the recommendations are followed. Nursing staff will then sign the Medical Consult. This procedure will be implemented by October 7, 2018.	10/7/18

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W 331	Continued From page 2 review of facility incident reports over the review year revealed client #2 to have documented falls on 9/18/17, 12/27/17, 3/18/18, 3/25/18, 4/5/18 and 5/19/18. A review of medical treatment after each fall revealed no further medical treatment necessary with exception of the fall on 5/19/18. Review of a 6/5/18 physical therapy (PT) consult revealed during the 5/19/18 fall, client #2 acquired a maxillary fracture and left orbital fracture bleed. Additional review of medical reports revealed injuries acquired during the 5/19/18 fall to resolve with no further treatment needed. Further review of the 6/5/18 PT consult revealed recommendations for client #2 to continue an in shoe lift and the use of a gait belt during the day due to a history of falls. The 6/5/18 PT consult further revealed the client to be at a moderate to high risk for falls in the future. Review of nursing notes for client #2 over the review year verified falls indicated in the facility incident reports and a nursing note on 6/21/18 revealed: "Gait belt recommended by OT. Gait belt ordered." Interview with the facility nurse revealed client #2 had started wearing a gait belt per the 6/5/18 recommendation by the physical therapist. Further interview with the facility nurse revealed she did not know a recommendation had been made by the neurologist in 7/25/17 relative to a gait belt due to not being employed by the facility at that time. Interview with administration staff revealed there had been changes in the nursing oversight and the neurology recommendation had been overlooked. Additional interview with the facility nurse verified client #2 should have had a gait belt furnished as of the 7/25/17 neurology consult. The facility nurse further verified client #2 had fallen seven times since the 7/25/17 gait belt recommendation, to include the fall on the	W 331		

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W 331	Continued From page 3 current survey day of 8/8/18. Subsequent interview revealed the facility protocol regarding head injuries related to falls require medical evaluation by the local emergency room or emergency clinic. Continued interview with the facility nurse further revealed there had been no formal guidelines implemented regarding the client's gait belt and no training had been provided to staff relative to the use of the client's gait belt.	W 331		