STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G077	A. BUILDING _____ B. WING _____	11/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE LANE GROUP HOME	121 BONNIE LANE STATESVILLE, NC 28625

(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 Complaint Intake #NC144525	W 000		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of facility records/documents and staff interview, the facility failed to show evidence that a thorough investigation for an allegation of abuse was conducted for 1 of 3 facility investigations reviewed. The finding is: Review of the facility's abuse/neglect investigations on 11/6/18 revealed an investigation started on 7/24/18 to determine the cause of bruising and swelling around client #6's left eye and cheek area. Continued review of the investigation revealed that on the evening of 7/23/18, nursing staff was contacted because client #6 had mild swelling around his left cheek area. Further review of the investigation revealed an incident report was completed on 7/23/18 with the nursing section indicating an approximate one inch scratch on the left cheek with some swelling along the jaw line. No bruising or swelling was noted. Continued review of the investigation report indicated that on the next morning, 7/24/18, the client was observed to have swelling and bruising to the face area and the client was sent to a local emergency department. Clinical supervision in the group home was started and an investigation into the injury was started. Review of the facility investigation conclusions	W 154		

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
	34G077	A. BUILDING _____ B. WING _____	11/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE LANE GROUP HOME	121 BONNIE LANE STATESVILLE, NC 28625

(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 1 revealed that following interview with 9 total staff including nursing and direct care staff, it was determined that client #6 had a behavioral incident in the kitchen area during the afternoon/evening of 7/23/18 where he exhibited very hyper and combative behavior after dropping to the floor. Further review of the conclusion revealed the client wears a helmet except during snack and meal times due to behaviors and a Stereotypical Movement disorder and indicated the helmet had been removed while the client was in the kitchen area assisting with food preparation. The client then dropped to the floor and engaged in combative behavior and the facility concluded this was the most likely cause of the injury. Recommended actions included in-servicing staff to ensure the client's helmet was not removed until at the dining table and the use of a soft helmet while at the table, updating the behavior support plan (BSP), review of client medications and increased "interaction assessments" for a 1 month period. Continued review of the facility investigations revealed an investigation started on 10/19/18 as an allegation of physical abuse associated with the incident which occurred on 7/23/18. Further review of the facility investigation revealed that on 10/19/18, the group home manager was informed by direct care staff member B, that direct staff member A may have physically abused client #6 on 7/23/18. Further review of the investigation indicated 2 direct care staff members were immediately suspended, including Staff A who was no longer working in the group home, but was still employed and working at another facility. The investigation included interviewing 6 direct care staff as well as the home manager.	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G077	A. BUILDING _____ B. WING _____	11/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE LANE GROUP HOME	121 BONNIE LANE STATESVILLE, NC 28625

(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 2 Review of the facility investigation conclusion revealed the facility did not substantiate physical abuse due to a lack of evidence. The conclusion did indicate that due to the "misrepresentation" of information, two direct care staff members received corrective action as well as retraining on immediately reporting reporting abuse and neglect. Additional recommendations included "interactions assessments" to be completed for Staff A two times weekly for 2 months, as well as communication training for all staff. Further review of the facility investigation indicated that none of the client's in the home were interviewed because they did not have "any orientation" to the incident and that client #6 was non-verbal. Review of the records for client's #1, #3 and #5 on 11/7/18 revealed they all had mild to moderate levels of intellectual disability. Client #3's person centered plan indicated he is able to verbally communicate his wants and needs. Observations in the group home on 11/6/18 and 11/7/18 revealed client's #1, #3 and #5 all communicating with at least minimal verbalizations. Interview with the qualified intellectual disabilities professional on 11/7/18 confirmed that client's #1, #3 and #5 were all able to verbally communicate at some level and indicated they were capable of being interviewed at some level related to staff treatment of all client's in the home. Interview with the facility administrator on 11/7/18 confirmed that interviewing client's during facility investigation is a part of the facility investigation process and should have been completed for this investigation.	W 154		
W 249	PROGRAM IMPLEMENTATION	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G077	A. BUILDING _____ B. WING _____	11/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE LANE GROUP HOME	121 BONNIE LANE STATESVILLE, NC 28625

(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 249	Continued From page 3 CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the team failed to assure sufficient interventions to address the communication needs for 2 of 3 sampled clients (#5 and #6). The findings are: A. The team failed to assure sufficient interventions to address the communication needs for client #5. For example: Observations during the 11/6-7/18 survey revealed client #5 to have minimal verbalizations. Staff were observed prompting the client verbally and with gestures. Examples of activities prompted included: snack preparation, going to the bathroom to wash hands, pack lunch for the next day, dinner, medication administration, breakfast, and getting ready for school. No communication tools were observed being used with client #5 during the survey observations. Review of the record for client #5 on 11/7/18 revealed a person centered plan (PCP) dated 2/27/18. The PCP indicated the client had a TEACCH schedule and indicated the client was	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G077	A. BUILDING _____ B. WING _____	11/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE LANE GROUP HOME	121 BONNIE LANE STATESVILLE, NC 28625

(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 249	Continued From page 4 very structured and scheduled and consistent use of the TEACCH schedule encouraged his success. Continued review of the record revealed a communication assessment completed 2/2/18 which included a need for the client to increase communication skills and recommended continued formal training to follow a TEACCH schedule throughout his daily routine. Further review of the PCP revealed a current communication program for client #5 to use his TEACCH schedule daily. The activities listed on schedule included: bathroom, getting dressed, breakfast, brushing teeth, medications and leisure. Interview with the facility qualified intellectual disabilities professional (QIDP) and habilitation specialist confirmed client #5's communication program objective to use a TEACCH schedule daily is current and staff should be implementing it as prescribed. B. The team failed to assure sufficient interventions to address the communication needs for client #6. For example: Observations during the 11/6-7/18 survey revealed client #6 to be non-verbal. Staff were observed prompting the client with verbalizations, gestures and sign language. Client #6 was also observed using sign language. Examples of activities prompted included: leisure/toys; dinner prep, dining, dressing, music, medications getting ready for school and getting on the van. Staff were observed using sign language with the client, but no other communication tools were observed being used during the survey observations.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G077	A. BUILDING _____ B. WING _____	11/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE LANE GROUP HOME	121 BONNIE LANE STATESVILLE, NC 28625

(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 249	Continued From page 5 Review of the record for client #6 on 11/7/18 revealed a PCP dated 3/21/18. The PCP indicated the use several signs to communicate as well as a TEACCH schedule. Continued review of the PCP revealed a current communication objective indicating the client would go to the designated area in his TEACCH picture schedule after the presentation of a picture and a gestural prompt with 90% accuracy for 2 months. The program indicated the training would be integrated into client #6's daily routine at the group home. The program directions to staff indicated staff were to provide the opportunity for transition from one activity to the next by giving him a cue "check your schedule". The directions indicated training will occur daily during the daily routine during all appropriate times. Interview with the QIDP and the habilitation specialist on 11/7/18 confirmed client #6's communication objective to use a TEACCH picture schedule is current and should have implemented it as prescribed.	W 249		