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 _____	C 12/13/2018

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 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have sufficient staff to address the identified needs of 1 of 6 clients (#6). The finding is: Record review for client #6 on 12/13/18 revealed a Habilitation Plan dated 11/15/18. Further review of the Habilitation Plan revealed an updated behavioral support plan (BSP) dated 10/25/18. Review of client #6's BSP revealed an interdisciplinary team's decision (IDT) on 10/9/18 which stated: the purpose is to revise and update plan and add inappropriate behaviors of entering others rooms, pica, inappropriate toileting, food seeking, grabbing others food, and keep client #6 safe. A one to one staff member will be assigned during all waking hours for client #6. Further review of the updated BSP revealed guidelines for the one to one staff of "keeping client #6 in eye sight at all times, being responsible for engaging client #6 in treatment/ leisure activities, and providing protective seating for all clients by seating himself (one to one staff) between client #6 during all meal times." Interview with the facility qualified intellectual disabilities professional (QIDP) on 12/13/18	W 186		

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
	34G184	A. BUILDING _____ B. WING _____	C 12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 186	Continued From page 1 confirmed the team recommendation was made on 10/9/18 for client #6 to have a one to one staff assigned. Continued interview with the QIDP revealed a one on one staff has not been hired for client #6 as of the current survey date. Further interview with the QIDP confirmed there is currently insufficient staff to provide for the identified needs of client #6. Therefore, the facility failed to have sufficient staff available to effectively implement the active treatment programs as defined in the Habilitation Plan to meet the specific needs of client #6.	W 186		