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

PRINTED: 01/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	34G184		C 01/17/2019

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 000	INITIAL COMMENTS	W 000	RECEIVED FEB 4 2019 DHSR NH L & C Black Mountain / WRO	
W 154	Complaint Intakes #NC00147188, #NC00147246 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 record review and interview the facility failed to ensure a thorough investigation was completed relative to the medical treatment and findings related to a choking incident of client #1. The finding is: Review of records for client #1 on 1/17/19 during a complaint investigation, revealed medical consult reports for 12/10/18 and 12/11/18. Review of the 12/10/18 medical consult revealed client #1 was taken to Novant Presbyterian emergency room (ER) due to choking and vomiting. Further review of the 12/10/18 medical consult revealed findings documented as: choking episode. Normal chest x-ray and vital signs. Recommendations revealed: Observe. Return only for shortness of breath, fever, or recurrent episode(s). Review of the 12/11/18 medical consult revealed client #1 was taken to the client's primary care doctor (PCP) for a follow up to ER visit on 12/10/18 with acute respiratory symptoms, cough, and dry heaving x 1 day. Further review of the 12/11/18 medical consult revealed findings of acute respiratory infection with cough with recommendations of medication: Doxcline 100 mg, Tessalon Perles 100mg and Mucinex DM.	W 154	LIFESPAN Residential has developed an Authorization for Disclosure that will allow LIFESPAN to obtain all pertinent medical documentation from Medical physicians, emergency and urgent care providers. This form will be will be signed by the guardian at intake and annually. LIFESPAN Residential managers and staff will be issued LIFESPAN photo IDs so they can be identified by medical professionals in a medical environment. In the case that an individual in ICF is receiving emergency, urgent care or in the case of hospitilization, nursing staff will ensure that all pertinent medical evaluations and documentation is obtained from attending medical professionals and or medical practice. These procedures will be monitored by the Residential Director, Qualified Professional, and the Registered Nurse.	This procedure will be implemented no later than March 17, 2019.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Sr. Director of Residential Services (X6) DATE: 1-22-19

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 154	Continued From page 1 Additional record review for client #1 revealed nursing notes that indicated on 12/11/18 day support staff called to report client #1 vomiting. Further review of nursing notes revealed client #1 was then taken to his PCP, treated for upper respiratory infection and discharged back to the group home. Nursing notes revealed client #1's guardian was present for the PCP visit and the guardian returned to the group home with client #1 and decided to take client #1 back to the ER due to the client continuing to not feel well and the guardian having concerns the client may have a bowel obstruction. Continued review of nursing notes revealed on 12/11/18 client #1 was admitted to the hospital. Nursing note on 12/12/18 revealed: Spoke to the guardian this morning. I haven't spoke to the MD, but from what I can gather from the guardian, client #1 does not have a bowel obstruction, but there was "stool seen on the x-ray, CT scan". Client #1 continues to have some difficulty swallowing and was waiting to be evaluated by the speech therapist. I asked the guardian to notify me if anything changes and to keep us updated on client #1's condition. Nursing note on 12/18/18 revealed: Spoke to the guardian this morning. Last night client #1 had a scope placed down his throat. The plan was to do a biopsy. Instead, client #1 was found to have a "piece of plastic" that looked like the top of a "salad dressing" bottle embedded in his throat. Fortunately object was removed. Nursing note on 12/19/18 revealed: Spoke to the hospital discharge case manager. She stated client #1 continues to have difficulty keeping his food down. He has reportedly passed the swallow evaluation. They are planning to discharge him	W 154		

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W 154	Continued From page 2 within the next few days provided he is able to keep food down. I explained to her that client #1 would not be able to return to the group home if the client is unable to hold his food down or had aspiration concerns as we are not a medical facility. According the the discharge planner, the guardian is planning to keep the client at her home while he recovers. Nursing note on 12/19/18 revealed: Notified by staff that the guardian of client #1 called the group home saying client #1 was discharged from the hospital and she was coming to get his medication from the group home since she was taking the client to her home. I advised staff to give the medication to the guardian just as they would for a therapeutic leave. Nursing note on 12/21/18 revealed: After speaking with supervisor, client #1 needs to be seen by his PCP before he returns to the group home. A staff member (nurse) is required to be present at the appointment. Interview with the facility qualified intellectual disabilities professional (QIDP) on 1/17/19 revealed client #1 remains with his guardian and verified the client has not returned to the group home since hospitalization in 12/2018. Further interview with the QIDP revealed client #1's guardian had informed the group home that a piece of plastic was found in the client's throat during hospitalization and this was the cause of the choking incident on 12/10/18. Further interview with the QIDP and administration staff verified an investigation was not initiated related to client #1's choking incident that was alleged by the guardian to have been caused by a piece of plastic. Administration staff	W 154		

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W 154	Continued From page 3 and the QIDP reported an email was used on 12/18/18 to explore the incident by obtaining the menu from 12/10/18 and determined no salad items were served and no bottles could be located in the group home without tops. Continued interview with the QIDP and administration staff revealed no interviews were conducted with staff relative to client #1's choking incident to determine if the client had swallowed anything plastic while in the home to determine if staff were monitoring the client appropriately or if the client's behavior plan needed to be modified. In addition, interview with the facility nurse on 1/17/18 revealed she had not followed up with client #1's treating physician during the hospitalization and had not requested medical documentation relative to the hospitalization. Further interview with the facility nurse verified she had not had contact with the client's guardian since the client was discharged from the hospital 12/19/18 to assist in investigating the nature of the item swallowed, how long it might have been there or the needs of the client to when he returns back to the group home.	W 154		