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W 000	INITIAL COMMENTS Intake# NC00156629 As referenced, not all deficiencies were corrected on the follow-up (W189 and W249) and an additional deficiency was cited as part of the complaint investigation (W154).	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 record review and interview the facility failed to ensure an investigation was completed relative to an injury of unknown origin for client #6. The finding is: A review of internal documentation on 11/14/19 revealed nursing notes that indicated on 9/26/19 staff called to report blood coming from a gash on the top of client #6's head. Further review of nursing documentation revealed the injury to client #6 was unwitnessed by staff and the cause of the injury was unknown. Nursing notes further documented staff were advised to transport client #6 to the emergency room for evaluation. A review of the facility's internal communication log on 11/14/19 verified on 9/26/19 client #6 was taken to the emergency room for a gash to the head. A review of the facility's internal incident reports revealed no report for client #6 on 9/26/19. Review of records for client #6 on 11/14/19 revealed an individual support plan (ISP) dated 11/15/18. Review of the 11/2018 ISP for	W 154		

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

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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client #6 revealed a behavior support plan for target behaviors of self-injurious behavior, aggression, elopement, inappropriate toileting, PICA, food seeking and destruction of clothing.

Interview with the facility home manager (HM) on 11/14/19 verified client #6 has a 1:1 staff due to the severity of behaviors and the need for close supervision. Further interview with the facility HM revealed she did not know why an incident report for client #6 on 9/26/19 was not in the facility's internal book for incident reports. Interview with administration staff on 11/14/19 revealed the incident of unknown origin for client #6 on 9/26/19 resulting in a gash to the client's head requiring external medical evaluation was not reported to administration. Additional interview with administration staff verified an inquiry/investigation should have been conducted relative to the head injury of client #6 on 9/26/19 as details of the injury are unknown and the client has an assigned 1:1 staff.

{W 189} STAFF TRAINING PROGRAM — {W 189}

CFR(s): 483.430(e)(1)

The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure staff were sufficiently trained in completing documentation relative to incident reports in the group home for 6 of 6 clients (#1, #2, #3, #4, #5 and #6.) The finding is:

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Review of incident reporting for the facility from 1/2019 through 8/2019 revealed no incident reports for 1/2019-5/2019. Incident reports were reviewed for 6/2019, 7/2019 and 8/2019.

Interview with QIDP confirmed she was unaware incident reports for the group home were not in the internal record book for incident reports during 1/2019-5/2019. The QIDP subsequently verified incident reports for 1/2019-5/2019 were unavailable for review and it was unknown if staff had completed incident reporting for the months of unavailable reports.

A follow up survey was conducted on 11/14/19 for all previous deficiencies cited on 8/20/19.

Based on record review and interviews, the facility failed to ensure staff were sufficiently trained in completing documentation relative to incident reports in the group home for 3 of 6 clients (#2, #3 and #6.) The finding is:

Review on 11/14/19 of internal documentation relative to the plan of correction for the recertification survey completed on 8/20/19 revealed staff received an in-service training on 9/19/19 conducted by the QIDP titled Incident Reports, proper notification and documentation.

A review of incident reports from 9/2019-11/2019 revealed incident reports for clients #2, #3 and #6. Further review of internal incident reports revealed incidents for client #2 on 11/4/19, client #3 on 10/23/19 and client #6 on 9/16/19, 9/18/19, 9/25/19 and 10/24/19.

A review of nursing notes on 11/14/19 revealed the following:

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{W 189}	Continued From page 3 On 8/31/19, staff reported client #3 was pushed to the floor by another individual while attempting to walk to the dinner table. Fall unwitnessed. Staff was advised to transport client to urgent care for evalaution. On 9/26/19 staff called to report blood coming from gash on top of scalp. Injury was unwitnessed by staff, cause unknown. Advised to transport to emergency room for evaluation. On 10/11/19 staff called to report client #2 had a fall while attempting to sit down on a shower chair sustaining an abrasion to the lower back. Referred to urgent care for evaluation. On 10/14/19 staff called to report client #3 demonstrating unsteadiness, in need of assistance to stand and a near fall. Advised staff to transport client to urgent care for evaluation. On 10/29/19 staff called to report client #6 to have a quarter sized abrasion to left elbow, advised staff to transport to urgent care for evaluation. Review of the internal communication log on 11/14/19 verified on 9/26/19 client #6 obtained a gash on the head and was taken to the emergency room for evaluation. Interview with the Home Manager (HM) on 11/14/19 confirmed she was unable to locate an incident report form for clients #2, #3 or #6 on 8/31/19. 9/26/19, 10/11/19, 10/14/19 and 10/29/19. Further interview with the HM verified that all client incidents resulting in a referral for extrernal medical evaluation should be	{W 189}		

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{W 189}	Continued From page 4 documented on an incident report form in the facility's incident report book. The HM subsequently verified all incident reports had not been completed by staff as required by the facility for injury/incident reporting.	{W 189}		
{W 249}	PROGRAM IMPLEMENTATION 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 observations, review of records and interviews the facility failed to ensure objectives listed in the individual habilitation plans (IHP's) were implemented as prescribed for 4 of 6 clients. The findings are: A. The facility failed to ensure ambulation guidelines and a communication objective for client #2 were implemented as prescribed. For example: 1. The facility failed to ensure ambulation guidelines for client #2. Observation of client #2 at the vocational program on 8/19/19 at 1:55 PM revealed the client to return from the bathroom to an activity table in the classroom. Client #2 was observed to ambulate	{W 249}		

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with staff assistance in a wheelchair. Further observation revealed client #2 to transfer from his wheelchair to a chair at the activity table using a two hand supported transition by staff. Staff was observed to stand in front of the client and hold both hands of the client while client #2 ambulated to the chair. Observation during the 8/19-20/19 survey did not reveal client #2 to wear a gait belt.

Review of records for client #2 on 8/20/19 revealed an individual habilitation plan (IHP) dated 5/5/19. Review of the IHP revealed a physical therapy (PT) evaluation dated 4/12/19. Review of the PT evaluation revealed a recommendation for an exercise regimen that included: 1) Moving sit to stand 10 times with upper extremity support. 2) Standing with 2 hands support (with walker or caregiver) 15 seconds to 1 minute. 3) Walking progressive distance starting with support from a walker. Contact guard assist from a caregiver is recommended. A gait belt is recommended.

A review of internal incident reports on 8/20/19 revealed on 6/26/19 client #2 had a fall while transitioning from a chair at the table to his wheelchair. Further review of the 6/26/19 incident report revealed client #2 to sustain a scrape on his back as a result of the fall. Additional review of records for client #2 revealed no guidelines to support staff with continuity in supporting client #2 with ambulation or transitions.

Interview with the facility nurse and qualified intellectual disabilities professional (QIDP) verified client #2 did not have guidelines to support ambulation or transitions. Further interview with the facility nurse and QIDP verified an in-service with staff had not been conducted

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relative to supporting client #2 with ambulation or transitions from his wheelchair. Interview with the QIDP further revealed client #2 had incurred one fall since admission in 4/2019. Subsequent interview with the facility nurse and QIDP verified client #2 did not have a furnished gait belt as recommended for transitions.

2. The facility failed to ensure a communication objective for client #2 was implemented as prescribed.

Observations throughout the 8/19-20/2019 survey revealed client #2 to participate in various activities to include an art activity with paint, meal participation, leisure activity (playing checkers with staff, watching television, holding hand held objects such as blocks), medication administration and loading the van for transport. During all observations, client #2 was verbally prompted regarding all transitions. At no time during observations were staff observed to use physical objects to support communication relative to a activity or schedule transition.

Review of records for client #2 on 8/20/19 revealed an individual habilitation plan dated 5/5/19. Review of the IHP revealed a communication objective relative to transitions implemented 5/2019. Further review of the communication objective revealed given specific visual prompts paired with objects to hold along with a physical escort to the corresponding area (med cup, toothbrush, spoon), client #2 will transition to specific tasks/activities. Further review of records for client #2 revealed a communication evaluation dated 5/10/19. Review of the 5/2019 communication evaluation revealed the need for programming for client #2 to

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{W 249}	Continued From page 7 increase receptive and expressive language skills. Interview with the qualified intellectual disabilities professional (QIDP) verified client #2's communication objective relative to transitions remained current and staff should have utilized physical prompts to support the client with transitions. B. The facility failed to ensure ambulation guidelines relative to a gait belt for client #4. For example: Observation of client #4 throughout the 8/19-20/19 survey revealed the client to ambulate with a walker. Observation of client #4 on 8/19/19 at the group home during afternoon observations revealed client #4 to also wear a gait belt underneath his shirt. Observation of client #4 on 8/20/19 in the group home during morning observations revealed the client to wear a gait belt on the outside of his clothing. Continued observations during ambulation of client #4 throughout the 8/19-20/19 survey revealed at various times staff held client #4's gait belt while the client ambulated while at other times staff stood close to client #4 without holding the gait belt. Review of records for client #4 on 8/20/19 revealed an IHP dated 1/29/19. Further record review for client #4 revealed no guidelines to support staff with continuity in supporting client #4 with ambulation. Interview with the facility nurse on 8/20/19 revealed staff should always hold client #4's gait belt during ambulation. The facility nurse further	{W 249}		

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verified client #4's gait belt should never be worn under the client's clothing. Subsequent interview with the facility nurse and QIDP verified guidelines specific to the needs of ambulation for client #4 had not been developed and an in-service with staff had not been conducted to address the use of a gait belt for client #4.

C. The facility failed to ensure a communication and meal preparation objective for client #3 were implemented as prescribed. For example:

1. The facility failed to ensure a communication objective for client #3 was implemented as prescribed.

Observation on 8/19/19 of the dinner meal revealed the place setting for client #3 to include a communication switch. Continued observation of the dinner meal revealed client #3 to participate in and complete the dinner meal and attempt to hit the communication device at his place setting that would not work. Client #3 was observed to hit the communication button multiple times until staff A and the QIDP acknowledged the client and indicated "it's ok, we need to put in a new battery".

Observation on 8/20/19 of the breakfast meal revealed the place setting for client #3 to include a communication switch. Continued observation of the breakfast meal revealed client #3 to participate in and complete the breakfast meal and attempt to hit the communication device at his place setting that would not work, and then begin attempting to hit the communication device of another client until staff A intervened and acknowledged client #3.

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Review of records for client #3 on 8/20/19 revealed an IHP dated 3/27/19. Further review of the IHP revealed a communication objective for client #3 to indicate "finished" at snack and meals with a big mack switch implemented 3/2019.

Interview with the QIDP on 8/20/19 verified client #3's communication objective relative to using a big mack switch at meals remains current. Further interview with the QIDP verified the communication device was not working at either meal due to the need for a new battery and the battery should have been replaced to allow for client #3 to run his communication program.

2. The facility failed to ensure a meal prepartation objective for client #3 was implemented as prescribed.

Observation in the group home on 8/19/19 at 4:45 PM revealed all clients to be engaged in various art and leisure activities. Further observation revealed all dinner items for the dinner meal to be prepared and on the stove with chicken nuggets in the oven. Observation at 5:20 PM revealed staff B to fix all client plates in the kitchen, cut all items to diet size appropriateness for all clients and to serve each client their individual plate at the dining table. Interview with the QIDP at 5:00 PM on 8/19/19 revealed the home manager had prepared all dinner items before clients returned home from their vocational program.

Review of records for client #3 on 8/20/19 revealed a IHP dated 3/27/19. Review of the IHP for client #3 revealed a meal preparation objective that client #3 will participate in meal preparation 3 times weekly (Mon, Wed, Fri) with staff assistance, implemented 3/2019.

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Interview with the QIDP confirmed client #3's meal preparation objective remains current and should have been implemented as written on 8/19/19. Further interview with the QIDP revealed she was unsure why the home manager had prepared the dinner meal before all clients had returned home and the meal should not have been prepared until the residents were home.

D. The facility failed to ensure a table setting objective for client #1 was implemented as prescribed. For example:

Observation in the group home on 8/19/19 at 5:20 PM revealed client #1 to complete an activity at the dining table and to wash his hands for the dinner meal. Further observation revealed client #1 to sit at the dining table until staff served his meal to him from the kitchen at 5:45 PM. Subsequent observation revealed staff A and B to provide each client with cups and their individual plates with dinner items from the kitchen.

Observation in the group home on 8/20/19 at 6:20 AM revealed client #1 to sit in the living room with a magazine, to socialize with various staff and survey members and to look at the television until staff A verbally prompted the client to the medication room. Observation at 7:05 AM revealed client #1 to enter the medication room and to exit the medication room to the dining table for breakfast. Client #1 was observed to sit at the dining table until staff C brought serving bowls from the kitchen with breakfast items, at no time was client #1 observed to assist with setting the table for the breakfast meal or prompted by staff to assist with setting the table.

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Review of records for client #1 on 8/20/19 revealed an IHP dated 1/25/19. Review of client #1's IHP revealed a training objective relative to setting the table during meal time implemented 1/2019. Further review of the table setting objective revealed client #1 will participate in setting the table during meal time with staff assistance with no more than 3 verbal prompts. Subsequent review of client #1's IHP revealed with encouragement, client #1 can participate in a wide array of domestic activities around the house.

Interview with the QIDP on 8/20/19 revealed client #1's table setting goal remains current and should have been implemented with each meal opportunity.

A follow up survey was conducted on 11/14/19:

Based on observations, review of records and interviews the facility failed to ensure objectives listed in the individual habilitation plans (IHP's) were implemented as prescribed for 3 of 6 clients. The findings are:

A. The facility failed to ensure a communication objective for client #2 was implemented as prescribed. For example:

Review of internal documentation on 11/14/19 relative to the plan of correction for the recertification survey completed on 8/20/19 revealed an in-service would be conducted to address staff utilizing the communication board for client #2. Review of trainings on 11/14/19 revealed no evidence of an in-service training for the communication needs of client #2.

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Interview with the facility home manager (HM) on 11/14/19 verified an in-service was not completed for the communication needs for client #2 relative to the clients communication board.

B. The facility failed to ensure ambulation guidelines relative to a gait belt for client #4. For example:

During the follow up survey on 11/14/19 observations at the day program from 1:15 PM to 1:30 PM revealed client #4 to transition with staff assistance in the day program with his gait belt underneath his shirt and jacket. Interview with the day program administration staff on 11/14/19 revealed that the facility had not provided training relative to the postion of client #4's gait belt during transition and ambulation support.

Review of internal documentation on 11/14/19 relative to the plan of correction for the recertification survey completed on 8/20/19 revealed a program would be created for client #4 to ensure his gait belt is always above his clothing during ambulation assistance. Subsequent review of the record for client #4 revealed an individual habilitation plan (IHP) dated 1/29/19. Continued review of the client record revealed a physical therapy (PT) assessment dated 9/19/19 stating that the gait belt for client #4 should be worn on the outer most layer of his clothing; and gait belt should not be placed over incisions, stitches, tubes, or lines. Further review of internal documentation revealed no evidence of an in-service training of the 9/19/19 ambulation guidelines for staff assisting client #4 in keeping his gait belt above his clothing during ambulation.

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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 249}	Continued From page 13	{W 249}		

Interview with the facility HM on 11/14/19 verified a program was not implemented for client #4 relative to ensuring his gait belt is worn above clothing during transition and ambulation. Further interview with the HM also confirmed that an in-service training was not completed relative to ambulation guidelines dated 9/19/19 for client #4.

C. The facility failed to ensure a communication objective for client #3 was implemented as prescribed. For example:

Observations at the group home on 11/14/19 at 8:30 AM revealed a communication device for client #3 to be located in the dining room. Further observation revealed the communication device was not in working order as the device was turned on and pushed by the surveyor. Subsequent observation revealed the HM to change the batteries in the communication device and the device to then work.

Review of internal documentation on 11/14/19 relative to the plan of correction for the recertification survey completed on 8/20/19 revealed an in-service would be completed to ensure the communication device for client #3 would function properly for his communication program during meals. The plan of correction further revealed the facility would keep backup batteries in the group home. Continued review of internal documentation revealed no evidence of an in-service relative to the communication device for client #3.

Interview with the HM on 11/14/19 verified an in-service was not completed for the communication needs of client #3. Further interview with the HM confirmed the

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 ______	R 11/14/2019

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BON REA DRIVE GROUP HOME	**3747 BON REA DRIVE** **CHARLOTTE, NC 28266**

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{W 249}	Continued From page 14 communication device should be working properly for client #3 to run his communication program during meals.	{W 249}		