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

PRINTED: 12/08/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G184	B. WING _	B. WING		C 11/25/2019	
NAME OF PROVIDER OR SUPPLIER BON REA DRIVE GROUP HOME			STREET ADDRE 3747 BON REA CHARLOTTE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BI DSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 111	health care, active treand protection of the and protection of the and protection of the Based on record revifacility failed to ensure clients (#6) was main to behavior managem. Review of records for revealed team meeting 9/19/19. Review of the documentation reveal details of the client to increase in food seek. Further review of the revealed the recomm diagnosis and treatme and associated aggree of team meetings for meeting since 9/19/20 records for client #6 rof qualified intellectual (QIDP) notes relative lack of progress since. Interview with administrevealed client #6 was from the facility on 11 with facility administrated determined that it was of care needed for client administration staff id	elop and maintain a in that documents the client's ratment, social information, client's rights. not met as evidenced by: ew and interviews, the expected keeping for 1 of 6 tained and accurate relative ment. The finding is: client #6 on 11/25/19 and documentation on the 9/19/19 team meeting led the current description reflect 1:1 reassigned, ing and toileting incidents. 9/2019 team meeting notes the endation to seek accurate the ent for ongoing food seeking the ent for ongoing food seeki	w W				

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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		34G184	B. WING			C 11/25/2019		
NAME OF PROVIDER OR SUPPLIER BON REA DRIVE GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION			
W 111	inability to provide the client #6. Subsequer administration staff v #6 had been notified to discharge on 11/2 with administration rehad not been located would be taken to the room on 11/27/19 and had not been located date. Facility administrations was unsure why propostatus of client #6 rel behaviors was not do record. Facility administration for the record of why the planned discipled been documented at guardian. PROGRAM DOCUM CFR(s): 483.440(e)(f) Data relative to accompecified in client indicated to the record of the recor	navior as to the facility's e appropriate level of care for nt interview with erified the guardian of client 10/1/19 of the facility's intent 7/19. Continued interview evealed a new placement I for client #6 and the client e local hospital emergency d dropped off if placement I by the identified discharge stration further reported he per documentation of the ative to an increase in target ocumented in the client's nistration additionally ure why there were no QIDP f client #6 since 6/11/19 and charge of client #6 had not a team meeting with the ENTATION I) mplishment of the criteria	W 15					
	Based on review of team failed to ensure management program	m listed in the individual r 1 of 6 clients (#6) was						

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		34G184	B. WING _			C 1/25/2019	
NAME OF PROVIDER OR SUPPLIER BON REA DRIVE GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 3747 BON REA DRIVE CHARLOTTE, NC 28266		1/23/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO' DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 252	revealed an individum 11/15/18. Review of behavior support plainjurious behavior, a inappropriate toiletin destruction of clothi ISP for client #6 revintellectual disability. Additional record reteam meeting docur of the 9/19/19 team revealed the currenclient to reflect 1:1 reseking and toiletin the 9/2019 team merecommendation to treatment for ongoin associated aggress team meetings for consince 9/19/2019. A client #6 revealed in intellectual disabiliting relative to interventing progress since 6/11 review of client #6 revealed revealed client #6 revealed revea	or client #6 on 11/25/19 ual support plan (ISP) dated of the 11/2018 ISP revealed a an for target behaviors of: self aggression, elopement, ng, PICA, food seeking and ng. Continued review of the realed a diagnosis of profound y, Autism and PICA. Eview for client #6 revealed mentation on 9/19/19. Review meeting documentation t description details of the reassigned, increase in food g incidents. Further review of eeting notes revealed the seek accurate diagnosis and ng food seeking and ion. Subsequent review of client #6 revealed no meeting dditional review of records for no documentation of qualified es professional (QIDP) notes ion progress or lack of /2019. Subsequent record revealed no behavior data or effect a recent increase in mistration staff on 11/25/19 vas expected to be discharged 11/27/19. Further interview tration revealed the facility had vas unable to provide the level	W	252			

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
W 252	client #6. Subsequer administration staff ve #6 had been notified discharge. Continued administration revealed been located for client taken to the local hos 11/27/19 and dropped been located by the idea of the facility administration unsure why proper doclient #6 relative to arbehaviors was not do record. Facility administration to the facility administration unsure why proper doclient #6 relative to arbehaviors was not do record. Facility administration in the record of	at interview with derified the guardian of client of the facility's intent to dinterview with ed a new placement had not at #6 and the client would be pital emergency room on doff if placement had not dentified discharge date. In further reported he was becumentation of the status of an increase in target cumented in the client's	W 2	2.52				