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	34G184	A. BUILDING _____ B. WING _____	06/16/2021

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

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W 226	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to implement a habilitation treatment plan within 30 days of admission for 1 of 6 sampled clients (#1). The finding is: Review of record for client #1 on 6/15/21 revealed an admission date of 10/23/20 but a habilitation treatment plan for client #1 with an implementation date of 10/4/20, 19 days before the client was even admitted into the group home. Continued review revealed a daily living skills assessment which should be used to develop the client's habilitation plan completed on 10/29/20. Interview with the qualified intellectual disabilities professional (QIDP) on 6/16/21 confirmed the habilitation treatment plan meeting for client #1 was held on 10/4/20. Further interview with the QIDP confirmed client #1's habilitation treatment plan should have been completed within thirty days after the client's admission to the facility to allow for assessments to be completed as required.	W 226		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by:	W 247		

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

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W 247	Continued From page 1 The facility failed to provide opportunities for client choice and self-management for 6 of 6 clients in the group home (#1, #2 #3, #4, #5 and #6) regarding meal preparation as evidenced by observation, interview and record verification. The finding is: Afternoon observations in the group home on 6/15/21 at 3:00 PM revealed staff to have food for supper cooking on the stove prior to the clients returning to the home from the day program. Pots of corn and spinach were noted to be cooking on the stove and turkey was cooking in the oven. Further observations from 3:50 PM until supper at 5:15 PM revealed limited client participation in meal preparation and was noted to only include client #1 partially setting the table at 4:10 PM, client #5 spooning food into serving bowls at 4:50 PM and client #3 helping to mechanically chop his food by pushing a button on the food processor at 5:05 PM. Continued afternoon observations revealed staff to complete all other aspects of meal preparation including gathering all food needed for supper, opening cans or bags of vegetables, placing turkey on the pan and into the oven, preparing water and making instant tea for supper, cutting up everyone's turkey in the kitchen and carrying all the food and drinks to the table. In addition, morning observations on 6/16/21 at 5:45 AM revealed staff in the kitchen making eggs and grits for breakfast without assistance from any clients. Further observations revealed the table to already be set and the clients, except client #3 who was taking a bath, to be sitting in the living room without any activity. Continued observations revealed staff completed all aspects	W 247		

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W 247	Continued From page 2 of meal preparation including preparing the client's plates with food in the kitchen before taking them to the table when breakfast started at 6:00 AM. Subsequent observations revealed staff also completed all clean up after the clients carried their dishes to the sink including washing the pots and pans, loading the dishwasher, wiping the table and counters and sweeping the floor. No client participation was noted at all during morning observations. Review of client habilitation programs and interview with the qualified intellectual disabilities professional (QIDP) revealed the clients to have varying degrees of interest and skill in helping with meal preparation tasks. For example: Review of client #4's habilitation plan dated 4/6/21 revealed the client to have an objective to participate in meal preparation at least 3 times a week while client #5's habilitation plan dated 1/23/21 noted the client needs some assistance but should be encouraged to participate in meal preparation. Observations during the survey revealed large amounts of afternoon and morning observations where the clients were sitting in the living room unengaged in activities while staff either sat with the clients or completed meal preparation activities. Staff failed to provide opportunities for choice and self-management in meal preparation especially when no other competing or conflicting activities were occurring.	W 247		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has	W 249		

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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:
The facility failed to assure a continuous active treatment program was provided for 6 of 6 clients in the home (#1, #2, #3, #4, #5 and #6) consisting of needed interventions and services in sufficient number and frequency to support the achievement of the the objectives identified in their habilitation plan as evidenced by observation, interviews, and record verification. The findings are:

A. For client #1, the facility failed to provide adequate active treatment to engage the client during large amounts of unstructured time. For example:

Afternoon observations in the group home on 6/15/21 from 3:50 PM until 5:40 PM revealed the client to sit unengaged without activity in the living room for 95 minutes of the 110 minutes of observation. During the remaining 15 minutes of observations, the client was observed to set the table with placemats, plates, spoons and cups.

Morning observations in the group home on 6/16/21 from 5:45 AM until the clients loaded the van for the day program at 7:30 AM revealed client #1 to sit on the living room couch with his head on the chair arm unengaged or walk back

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and forth to his room without any activity for 70 minutes of the 95 minutes of observation. During the remaining 25 minutes of observations, the client was noted to eat breakfast and to take out the trash. Only staff C was observed to attempt to engage the client by prompting him to obtain his tablet at 6:25 AM without success.

Review of client #1's habilitation plan dated 10/4/20, substantiated by interview with the qualified intellectual disabilities professional (QIDP), revealed the client to have objective training to take clothing items to washing machine, make his bed, brush his teeth, toileting, pick out clothes for next day, and complete a full shower.

Interview with the QIDP revealed the facility is currently experiencing a staff shortage and has been using fill-in staff from other homes that may not be as familiar with the clients. Further interview revealed staff should be implementing client #1's active treatment programing throughout the day and helping the clients with meaningful activities during afternoon and morning periods of inactivity.

B. For client #2, the facility failed to implement his communication and fine motor skills program as well as provide adequate active treatment to engage the client during large amounts of unstructured time. For example:

Afternoon observations in the group home on 6/15/21 from 3:50 PM until 5:40 PM revealed the client to sit unengaged without activity in the living room for 78 minutes of the 110 minutes of observations. During the remaining 32 minutes of observation, the client was observed to go

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outside and check the mail with staff and eat supper.

Morning observations in the group home on 6/16/21 from 5:45 AM until the client's loaded the van for the day program at 7:30 AM revealed client #2 to sit on the living room couch unengaged without any activity for 70 minutes of the 95 minutes of observation. During the remaining 25 minutes of observations, the client was noted to eat breakfast and take medications.

Review of client #2's habilitation plan dated 1/19/21, substantiated by interview with the QIDP, revealed the client to have objective training to use a digital picture/board to direct choice making of activities, cardiovascular fitness, toothbrushing for 60 seconds, address drink choice, select a leisure activity with picture board, use bathroom every 3 hours, and set the table during mealtime.

Further review of the client 's habilitation plan revealed the use of picture board symbols to be used by client #2 to help direct the choice making of leisure activities. Observations during the 6/15-16/21 survey revealed no use of any items to help engage client in a leisure activity.

Interview with the QIDP revealed the facility is currently experiencing a staff shortage and has been using fill-in staff from other homes that may not be as familiar with the clients. Further interview revealed staff should be implementing client #2's active treatment programing throughout the day and helping the clients with meaningful activities during afternoon and morning periods of inactivity.

C. For client #3, the facilty failed to implement his

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communication and fine motor skills programs as well as provide an adequate active treatment program to engage the client during large amounts of unstructured time. For example:

Afternoon observations in the group home on 6/15/21 from 3:50 PM until 5:40 PM revealed the client to sit unengaged without activity in his wheelchair in the living room for 80 minutes of the 110 minutes of observation. During the remaining 30 minutes of observation, the client was observed to roll his wheelchair into the kitchen with assistance to help process his food and to eat supper.

Morning observations in the group home on 6/16/21 from 5:55 AM until the clients loaded the van for the day program at 7:30 AM revealed client #3 to sit in his wheelchair in the living room unengaged without any activity for 70 minutes of the 95 minutes of observations. During the remaining 25 minutes of observations, the client was noted to eat breakfast and take medication. Only staff C was observed to attempt to engage the client with a leisure item on one occasion at 6:25 AM without success.

Review of client #3's habilitation plan dated 6/3/21, substantiated by interview with the QIDP, revealed the client to have objective training to slow rate of eating, brush teeth, wash upper body, toilet every 3 hours, use an output switch to indicate he is finished at snack and meals, sort by shapes to improve fine motor skills and to use specific objects to learn to transition to activities.

Further review of the client's habilitation revealed objects to be used by client #3 to help with transitions included a medication cup for

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medication time, a toothbrush for toothbrushing and a spoon to represent meal times. Observations during the 6/15-16/21 survey revealed no use of any items to help the client with transitions even though 2 meals and a medication pass were observed.

Continued observations during the survey revealed the client was not engaged in his fine motor skills objective or other leisure activies during the client's 2 hours of unengaged observations. In addition, the client's output switch program to indicate when he was finished, was only used at breakfast on 6/16/21 and not at supper on 6/15/21.

Interview with the QIDP revealed the facility is currently experiencing a staff shortage and has been using fill-in staff from other homes that may not be as familiar with the clients. Further interview revealed staff should be implementing client #3's active treatment programming throughout the day and helping the clients with meaningful activities during afternoon and morning periods of inactivity.

D. For client #4, the facility failed to implement 5 of 6 objectives and failed to provide an adequate active treatment to engage the client during large amounts of unstructured time. For example:

Afternoon observations in the group home on 6/15/21 from 3:50 PM until 5:40 PM revealed the client to sit unengaged without activity in the living room for 75 minutes of the 110 minutes of observations. During the remaining 35 minutes, the client was observed to take his medication and go to the bathroom, eat supper and put his dishes in the sink after supper.

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Morning observations in the group home on 6/16/21 from 5:45 AM until the clients left for the day program at 7:30 AM revealed client #4 to sit unengaged in the living room without activity for 60 of 95 minutes of observations. During the remaining 35 minutes, the client was observed to eat breakfast, take medications and go to the bathroom.

Review of client #4's habilitation plan dated 4/6/21, substantiated by interview with the QIDP, revealed the client to have objective training to put dishes in the dishwasher, exercise, participate in meal preparation 3 times a week, participate in leisure activities, seek mealtime related information and use a go talk communication device. Continued observations during the survey revealed none of the client's objectives were implemented except the use of the client's go talk device at meals.

Interview with the QIDP revealed the facility is currently experiencing a staff shortage and has been using fill-in staff from other homes that may not be as familiar with the clients. Further interview revealed staff should be implementing client #4's active treatment programming throughout the day and helping the clients with meaningful activities during afternoon and morning periods of inactivity.

E. For client #5, the facility failed to implement his choice leisure program and failed to provide an adequate active treatment program to engage the client during large amounts of unstructured time. For example:

Afternoon observations in the group home on

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6/15/21 from 3:50 PM to 5:40 PM revealed the client to sit unengaged without activity for 50 of 110 minutes of observation. During the remaining 60 minutes of observation the client was observed to use the bathroom, spoon food into serving bowls and eat supper.

Morning observations in the group home on 6/16/21 from 5:45 AM until the clients left for the day program at 7:30 AM revealed client #5 to sit unengaged for 65 of 95 minutes of observation. During the remaining 30 minutes of observation, the client was only noted to eat breakfast and take medications.

Review of client #5's habilitation plan dated 1/23/21 revealed the client to have 5 objectives including an objective to participate in a choice leisure activity. Continued observations in the home during the survey revealed staff did not implement this objective with client #5.

Interview with the QIDP revealed the facility is currently experiencing a staff shortage and has been using fill-in staff from other homes that may not be as familiar with the clients. Further interview revealed staff should be implementing client #5's active treatment programming throughout the day and helping the clients with meaningful activities during afternoon and morning periods of inactivity.

F. For client #6, the facility failed to implement the client's exercise program or provide an adequate active treatment program to engage the client during large amounts of unstructured time. For example:

Afternoon observations in the group home on

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W 249	Continued From page 10 6/15/21 revealed the client to sit in a living room chair unengaged 70 of the 110 minutes of observations. The only activity the client participated in during the remaining 40 minutes was eating supper. Morning observations in the group home on 6/16/21 revealed client #6 to sit in his wheelchair unengaged for 70 of 95 minutes of activity from 5:45 AM until loading the van at 7:30 AM. During the remaining 25 minutes of observation, the client was observed to eat breakfast and take his medication. Review of client #6's habilitation plan dated 7/27/20 revealed the client to have 5 objectives including an objective to participate in exercise using arm weights. Continued observations in the home during the survey revealed staff did not implement this objective with client #6 or attempt to engage the client in meaningful leisure activity. Interview with the QIDP revealed the facility is currently experiencing a staff shortage and has been using fill-in staff from other homes that may not be as familiar with the clients. Further interview revealed staff should be implementing client #6's active treatment programming throughout the day and helping the clients with meaningful activities during afternoon and morning periods of inactivity.	W 249		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration.	W 382		

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W 382	Continued From page 11 This STANDARD is not met as evidenced by: The facility failed to assure medications in the group home were kept locked except when being prepared for administration as evidenced by observation and record verification. The finding is: Morning observations on 6/16/21 during the morning medication pass revealed staff to leave the medication room on 6 occasions while leaving medication cabinet open or medications sitting on the counter in the medication room. It was also noted at times clients were left in the room without supervision. For example: Observations at 6:15 AM revealed staff B to walk out of the medication room with the medication cabinet open and medications sitting on the counter with client #6 sitting in the doorway of the medication room. Further observations revealed staff B walked out for various reasons at 6:21 AM, 6:36 AM and 6:38 AM again without assuring that the clients' medications were secured. Continued observation at 6:41 AM revealed staff B left the medication room at 6:41 AM with client #2 standing in the medication room beside his medications before being prompted by the qualified intellectual disabilities professional (QIDP) to return to the medication room. Subsequent observations at 7:11 AM revealed the medications were once again left unlocked and unattended.	W 382		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils.	W 475		

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This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure all appropriate utensils were provided for 6 of 6 clients in the home (#1, #2, #3, #4, #5, #6) for 2 of 2 meals. The findings are:

Observations in the group home during the 6/15-16/21 revealed clients were only given spoons to eat with at both meals observed even though clients have the ability or the need to use a fork and knife. For example:

A. The facility failed to provide appropriate utensils to client #1.

Observation in the group home on 6/15/21 at 5:15 PM revealed client #1 to eat supper with a place setting that consisted of a plate, spoon, and 2 cups. Continued observation revealed the dinner meal to include turkey chops, spinach, and corn. Subsequent observation revealed client #1 to use a spoon to eat all meal items.

Observation in the group home on 6/16/21 at 6:00 AM revealed client #1 to eat breakfast using a divided dish, spoon and cups. Continued observation revealed the breakfast meal to include bananas, eggs, and grits. Subsequent observation revealed client #1 to use a spoon to eat all meal items.

Review of records for client #1 on 6/16/21 revealed a habilitation plan dated 10/4/20. Review of habilitation plan for client #1 revealed meal preparation goals for client #1 to utilize regular utensils and plate. Further review of record revealed a daily living skills assessment

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for client #1 dated 10/29/20 which noted dining for client #1 included the use of a fork to pierce food with supervision, the use of a knife and fork to cut food with assistance and the use of a knife to spread with assistance.

Interview with the qualified intellectual disabilities professional (QIDP) on 6/16/21 revealed client #1 can use a fork and spoon at meals. Continued interview with QIDP confirmed client #1 should be provided a fork and spoon at all meals.

B. The facility failed to provide appropriate utensils to client #2.

Observation in the group home on 6/15/21 at 5:15 PM revealed client #2 to eat dinner using a place setting that consisted of a plate, spoon and 2 cups. Continued observation revealed the dinner meal to include turkey chops, spinach, and corn. Subsequent observation revealed client #2 to use a spoon to eat all meal items.

Observation in the group home on 6/16/21 at 6:00 AM revealed client #2 to eat breakfast using a place setting that consisted of a divided dish, spoon and cups. Continued observation revealed the breakfast meal to include bananas, eggs, and grits. Subsequent observation revealed client #2 to use a spoon to eat all meal items.

Review of records for client #2 revealed a habilitation plan dated 1/19/21. Continued review of client #2's habilitation plan revealed dining skills for client to use a fork and spoon to feed himself. Further review of records for client #2 revealed a nutritional evaluation dated 3/29/20 which noted the client feeds self, needs some prompting, uses regular utensils, plate and knife.

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 _____	06/16/2021

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 475	Continued From page 14	W 475		

Interview with the QIDP on 6/16/21 revealed client #2 can use a fork and spoon at meals. Continued interview with the QIDP confirmed client #2 should be provided a fork and spoon at all meals.

C. The facility failed to provide appropriate utensils for client #4.

Observation in the group home on 6/15/21 at 5:15 PM revealed client #4 to eat dinner using a place setting that consisted of lip dish with guard, spoon and 2 cups. Continued observation revealed the dinner meal to include turkey chops, spinach and corn. Subsequent observation revealed client #4 to use a spoon to eat all meal items.

Observation in the group home on 6/16/21 at 6:00 AM revealed client #4 to eat breakfast using a place setting that consisted of a lip dish with guard, spoon and cups. Continued observation revealed the breakfast meal to include bananas, eggs, and grits. Subsequent observation revealed client #4 to use a spoon to eat all meal items.

Review of records for client #4 on 6/16/21 revealed a habilitation plan dated 4/6/21. Review of habilitation plan for client #4 revealed dining skills for client to feed himself using a regular spoon and fork. Continued review of record revealed a daily living skills assessment for client #4 dated 3/27/20 which noted dining skills for client #4 included the use of a fork to pierce food with supervision, the use of a knife and fork to cut food with assistance and the use of a knife to spread with assistance.

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 _____	06/16/2021

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 475	Continued From page 15 Interview with the QIDP on 6/16/21 revealed client #4 can use a fork and spoon at meals. Continued interview with QIDP confirmed client #4 should be provided a fork and spoon at all meals.	W 475		