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 08/19/2021

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 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure medical care relative to scheduling and ensuring follow-up care in a timely manner for client #5. The finding is: Review of internal records on 8/19/21 during a complaint investigation revealed an incident report dated 8/2/21. Review of the incident report revealed that client #5 arrived at the day program with a gait belt attached around his body and wheelchair. Continued review of the 8/2/21 incident report revealed the day program qualified intellectual disabilities professional (QIDP) removed client #5's gait belt due to restrictive concerns of how the belt was tied to the client. Continued review of internal records revealed an internal investigation dated 8/2/21. Review of the internal investigation revealed that during the interview of two group home staff, it was discovered that client #5 was involved in an incident several weeks prior in which the client slid out of his wheelchair onto the van floor while staff were loading the client onto the van. Continued review of the internal investigation revealed after client #5 slid into the floor of the facility van, two staff assisted the client back into his wheelchair and prepared for van transport. Further review of the internal investigation revealed the staff involved with client #5's fall did not follow agency protocol and did not make the nurse or management aware of the incident.	W 322		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/01/2021

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 08/19/2021

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 322	Continued From page 1 Review of records for client #5 on 8/19/21 revealed no medical consults or nursing notes relative to a recent fall. Continued review of internal records revealed (2) head and body check forms dated 7/30/21 and 7/31/21 that revealed no injuries or new markings on client #5's body. Interview with the facility nurse on 8/19/21 revealed that she was not aware that client #5 had experienced a recent fall from his wheelchair. Continued interview with the facility nurse also verified staff are required to communicate all incidents to nursing and management when an incident occurs. Further interview with the facility nurse revealed staff are also required to complete an incident report and body check with all incidents involving a client. Subsequent interview with the facility nurse revealed that if she was aware that client #5 had experienced a fall from his wheelchair, she would have recommended that staff transport the client to outside medical care for evaluation. Interview with the facility compliance specialist on 8/19/21 verified that she initiated an internal investigation upon knowledge that client #5 had presented at the day program with a gait belt strapped around the client's body and wheelchair. Continued interview with the compliance specialist verified that upon completion of the 8/2/21 internal investigation, the allegations relative to neglect were unsubstantiated. Interview with the compliance specialist further verified that investigation recommendations included the following: that client #5 receive a follow up appointment with his primary care physician, that staff involved in the incident	W 322		

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 08/19/2021

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 322	Continued From page 2	W 322		

receive disciplinary action, and staff members receive in-service training relative to appropriate/timely incident reporting and appropriate use of adaptive equipment.

Interview with the facility qualified intellectual disabilities professional (QIDP) on 8/19/21 verified that he was aware client #5 had arrived at the day program with a gait belt wrapped around the client's body and wheelchair on 8/2/21. Further interview with the QIDP verified that as a result of client #5's incident involving a fall from his wheelchair, one of the staff members involved was terminated and the second staff would receive corrective action and additional training due to not reporting incidents timely. The QIDP also confirmed that nursing should be made aware of all incidents involving clients to ensure clients receive appropriate and timely medical attention. Further interview with the QIDP verified that, as of the current survey date, he had not made the facility nurse aware of the incident involving client #5.

Subsequent interview with the QIDP confirmed that he was responsible for scheduling medical appointments and he had not scheduled any appointment for client #5 as recommended with the findings of the 8/2/21 internal investigation. The QIDP additionally verified he had received the recommendations of the 8/2/21 investigation on 8/4/21 and client #5 had not received any medical attention or appointments to date relative to the fall from his wheelchair.