

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BONNIE LANE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 121 BONNIE LANE STATESVILLE, NC 28625
---	---

(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	<p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the team failed to assure sufficient interventions to address the communication needs for 2 of 3 sampled clients (#3 and #6). The findings are:</p> <p>A. The team failed to assure sufficient interventions to address the communication needs for client #3. For example:</p> <p>During observations at the group home on 10/11/21 and 10/12/21 revealed client #3 to be nonverbal. Staff were observed prompting the client verbally and with gestures. Examples of activities prompted included: going to his bedroom, choosing an activity, washing hands, fixing his plate, dinner, clearing his place at the table and taking dishes to the sink. Further observations on 10/12/21 at 5:30 AM revealed staff prompting the client verbally and with gestures. Examples of activities prompted included: sitting at the table, breakfast, medication administration, going to the living room area and loading on the van. No communication tools were observed being used</p>	W 249		
-------	---	-------	--	--

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.

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

PRINTED: 10/15/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/12/2021
NAME OF PROVIDER OR SUPPLIER BONNIE LANE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 121 BONNIE LANE STATESVILLE, NC 28625		
(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	<p>Continued From page 1 with client #3 during the observations.</p> <p>Review of client #3's record on 10/12/21 revealed a person centered plan (PCP) dated 12/15/20 with a diagnosis to include Autism. The PCP indicated the client had a current communication objective indicating that staff will present the client the opportunity to utilize the TEACCH schedule representing designated activities or events in his schedule. Continued review revealed client #3 would go to the designated area in his TEACCH picture schedule after the presentation of a picture and a gestural prompt with 90% accuracy for 2 months. The program directions to staff indicated staff were to provide the opportunity for transition from one activity to the next by giving him a cue "check your schedule". The directions indicated training will occur daily during the daily routine during all appropriate times.</p> <p>Interview on 10/12/21 with the facility qualified intellectual disabilities professional (QIDP) and habilitation specialist confirmed client #3's communication program objective to use a TEACCH schedule is current and staff should be implementing as prescribed.</p> <p>B. The team failed to assure sufficient interventions to address the communication needs for client #6. For example:</p> <p>Observations in the group home on 10/11/21 and 10/12/21 survey revealed client #6 to be nonverbal. Staff were observed prompting the client verbally and with gestures. Examples of activities prompted included: sitting in the dining area, participate in medication administration, sit on the ground outside and transition back and forth from outside to his bedroom. Further</p>	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/12/2021
NAME OF PROVIDER OR SUPPLIER BONNIE LANE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 121 BONNIE LANE STATESVILLE, NC 28625		
(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	<p>Continued From page 2</p> <p>observations at 5:20 PM revealed staff C attempting to request client #6 to go to the bathroom to wash his hands for the dinner, utilizing only a verbal prompt of "let's go to the bathroom". Client #6 ambulated to the bathroom with staff C after five minutes of repeated verbal prompts and sitting outside on the ground. Continued observations at 5:15 PM to 6:00 PM revealed client #6 to participate in dinner meal, refuse to take his dishes to the kitchen and then go outside to sit on the park bench.</p> <p>Observations on 10/12/21 at 6:00 AM revealed client #6 to transition from his room to the kitchen area and sit on the floor. Further observations revealed the client to transition to the dining area to participate in breakfast. Staff C then request client #6 to transition from the breakfast table to the living room. After three minutes of repeated verbal requests client #6 entered the living room area. Continued observations at 6:50 AM revealed client #6 to participate in medication administration then sit on the kitchen floor. During all of the above observations there was no utilization of a TEACCH schedule or picture cues by staff members to assist client #6 to make transitions from activity to activity, or from room to room in the group home.</p> <p>Review of client #6's record on 10/12/21 revealed a PCP dated 2/24/21 with a diagnosis to include Autism. Continued review revealed a communication objective "to go to the designated area noted in a TEACCH picture schedule after the presentation of a picture and a partial physical prompt with 80% accuracy." Further review revealed a communication evaluation for client #6 dated 2/11/19 with recommendations of labeling the common environment with picture signs,</p>	W 249			

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

PRINTED: 10/15/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/12/2021
NAME OF PROVIDER OR SUPPLIER BONNIE LANE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 121 BONNIE LANE STATESVILLE, NC 28625		
(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 3 using manual signing with client #6, and continuing to train client #6 to respond to the TEACCH schedule in the home.	W 249			
W 475	<p>Interview with the QIDP and the habilitation specialist on 10/12/21 confirmed client #6's communication objective to use a TEACCH picture schedule is current and staff should have implemented it as prescribed.</p> <p>MEAL SERVICES CFR(s): 483.480(b)(2)(iv)</p> <p>Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to provide appropriate adaptive equipment for 1 of 3 sampled clients (#3). The finding is:</p> <p>Observations at the group home on 10/11/21 during the dinner meal revealed client #3 was seated at the dining table at 5:30 PM and was provided with a place setting consisting of a regular plate, cups and utensils. Further observations revealed client #3 ate his meal using a spoon. Continued observations revealed client #3 turned the spoon in several different directions as he attempted to eat his meal which consisted of beef stroganoff, broccoli, and cookies. Subsequent observations revealed client #3 to respond and receive second and third serving of beef stroganoff. Additional observations revealed client #3 to turn his plate toward the left, and used his spoon to scoop toward the right, causing food to spill from the dish onto the table, chair and floor. Further observations revealed client #3 to continue eating his meal using the fingers to prevent his food</p>	W 475			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/12/2021
NAME OF PROVIDER OR SUPPLIER BONNIE LANE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 121 BONNIE LANE STATESVILLE, NC 28625		
(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	<p>Continued From page 4 from spilling onto the table.</p> <p>Observations conducted during the breakfast meal on 10/12/21 revealed client #3 ate his breakfast at 6:30 AM and was provided with a place setting consisting of a regular plate, cups and utensils. Further observations revealed client #3 attempted to eat his meal which consisted of waffles, scrambled eggs and bacon. Continued observations revealed client #3 to eat at a rapid pace while turning his plate to pick up the items to place in his mouth and food would spill while trying to scoop it up from the plate. Subsequent observations revealed the majority of client's breakfast meal to spill unto the chair and floor.</p> <p>A review of client #3's record on 10/12/21 revealed a person centered plan (PCP) dated 12/15/20 which contained an occupational therapy evaluation dated 11/30/20 which documented client #3 should utilize a small spoon and high divided dish during all meals.</p> <p>An interview conducted on 10/12/21 with the qualified intellectual disabilities professional (QIDP) revealed client #3 should utilize a high-sided divided dish during meals as prescribed in the PCP.</p>	W 475			