

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

PRINTED: 09/01/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2021
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	<p>PHYSICIAN SERVICES CFR(s): 483.460(a)(3)</p> <p>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:</p> <p>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.</p> <p>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.</p>	W 322	<p>QIDP will complete a full In-Service educating all staff on how to properly use "Gait Belt" on an Individual. QIDP will complete a full In-Service on how to complete Incident Report and When should Incident Report be completed. Nursing will be consulted immediately regarding any incidents that may involve an injury to the individual so that appropriate medical care can be obtained in a timely manner.</p> <p>Ongoing monitoring from these In-Service will be completed and documented by QIDP.</p> <p>In accordance with LIFESPAN's Investigation Policy, upon completion of an investigation, the Quality Assurance Specialist will share the conclusion and recommendations with the Qualified Professional. If there are any discoveries during the investigation that may have resulted in an injury or illness of the individual, the nursing department will be notified of this finding. The Qualified Professional shall then consult with the Sr. Director of Residential and if applicable,</p>	<p>In-Service will be completed by 9/14/21. Monitoring will be ongoing</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

9-13-2021 (X6) DATE
11/01/2021

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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W 322	<p>Continued From page 1</p> <p>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.</p> <p>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.</p> <p>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</p>	W 322	<div style="border: 1px solid black; padding: 5px;"> <p>Human Resources to discuss the recommendations. If it is determined that the recommendations are relevant and appropriate, they will be implemented. The Qualified Professional shall provide notification to the Quality Assurance Specialist if and when the recommendation have been implemented. Implementation of these recommendations will be tracked by the Quality Assurance Specialist.</p> </div>		

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NAME OF PROVIDER OR SUPPLIER

BON REA DRIVE GROUP HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

3747 BON REA DRIVE

CHARLOTTE, NC 28266

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W 322	<p>Continued From page 2</p> <p>receive disciplinary action, and staff members receive in-service training relative to appropriate/timely incident reporting and appropriate use of adaptive equipment.</p> <p>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.</p> <p>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.</p>	W 322		