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

PRINTED: 05/05/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TION AND IN I		(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		34G077	B. WING			C 04/27/2023		
NAME OF PROVIDER OR SUPPLIER					FADDRESS, CITY, STATE, ZIP CODE	1 04/	2172020	
BONNIE	LANE GROUP HOME	i.			ONNIE LANE ESVILLE, NC 28625			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETION		
W 000	INITIAL COMMEN	ΤS	w o	00				
W 154	Intake #00201365.	was completed on 4/27/23 for The complaint was dowever, deficiencies were	W 1	54				
Wild	CFR(s): 483.420(d) The facility must haviolations are thoroughly instructional period of facility failed to ensity the facility failed to ensity facility facilit	ave evidence that all alleged ughly investigated. In some that as evidenced by: eviews and interviews, the seriews and interviews, the seriews and interviews, the seriew and allegation of abuse was ated after immediately in the reported incident. The ecords/documents on 4/27/23 all inquiry conducted, no internal sected, and no incident reports ility for report of abuse 23. On 4/27/23 revealed a time the dates 4/9/23 to 4/29/23. In the time sheet revealed staff						
	102.05 Abuse, Neg that all staff are rec	of the facility's internal policy plect and Exploitation revealed puired to immediately report.						
	Services Manual re Neglect and Exploi the failure to provid necessary to protect	of the facility's NC/MH/IDD/SU evealed policy 102.05 Abuse, tation which defines neglect as le services and supports a person from serious echological harm. Continued						
LABORATOR'	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		34G077	B. WING _		l l	C / 27/2023	
NAME OF PROVIDER OR SUPPLIER BONNIE LANE GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 121 BONNIE LANE STATESVILLE, NC 28625	1 3.11	2172020	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE		
W 154	has zero tolerance unintentional negle significant risk of his staff involved in incomplete of carelessness, or that results in no his receiving services of management and rup to and including. Interview on 4/27/2 leader (RTL) revea on 4/20/23 via text regarding DSS investigation of the product of the pr	y's policy revealed the facility for intentional neglect or ct that results in harm or arm. Actions taken toward idents that occur due to an act mission, accident or distraction arm or risk to a person will be determined by may include disciplinary action termination. 3 with the residential team led that the RTL was notified message from the QIDP estigation. Continued interview at that an investigation should ed. ith RTL verified that no body after the alleged incident was	W 15	54			
W 155	verified measures to not been taken with an allegation of an with the VP of Operan internal inquiry sand staff should has STAFF TREATMENT CFR(s): 483.420(d). The facility must provide the investigated This STANDARD is Based on record refacility failed to imperotection measures.)(3) event further potential abuse	W 15	55			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		34G077	B. WING _		04	/ 27/2023	
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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ROVIDER'S PLAN OF CORRECTION (X5) COMPLE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 155	Continued From pa	age 2	W 15	5			
	sheet for staff A for Continued review or revealed that staff Review on 4/27/23 Services Manual re Neglect and Exploithe failure to provion necessary to prote physical and/or psyreview of the facilith has zero tolerance unintentional negles significant risk of his staff involved in incof carelessness, out that results in no him receiving services	on 4/27/23 revealed a time of the dates 4/9/23 to 4/29/23. Of the time sheet for staff A A worked assigned shifts. To of the facility's NC/MH/IDD/SU evealed policy 102.05 Abuse, itation which defines neglect as de services and supports of a person from serious cychological harm. Continued by spolicy revealed the facility of for intentional neglect or ext that results in harm or earm. Actions taken toward cidents that occur due to an act mission, accident or distraction arm or risk to a person will be determined by may include disciplinary action of termination.					
	leader (RTL) reveal on 4/20/23 via text regarding DSS invited with the RTL verification between conductive verified that no botalleged incident was of staff. Interview with the fiverified measures not been taken with an allegation of an	23 with the residential team aled that the RTL was notified message from the QIDP estigation. Continued interviewed that an investigation should ted. Further interview with RTL dy checked the clients after the as conducted and no removal facility administrator on 4/27/23 to ensure client protection had h regards to being notified of abuse. Interview with the VP 27/23 verified that an internal					

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		34G077			С		
NAME OF F	PROVIDER OR SUPPLIER	340077	D. Wiite	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	27/2023	
BONNIE LANE GROUP HOME			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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		JLD BE	(X5) COMPLETION DATE	
W 155	·	ernal investigation and staff	W				